HEARING ON H.R. 788, H.R. 789, H.R. 1303, H.R. 1818, AND H.R. 2227

HEARING

BEFORE THE

SUBCOMMITTEE ON
HOSPITALS AND HEALTH CARE

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

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HEARING ON H.R. 788, H.R. 789, H.R. 1303, H.R. 1818, and H.R. 2227

THURSDAY, MAY 2, 1985

House of Representatives,
Subcommittee on Hospitals and Health Care,
Committee on Veterans' Affairs,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:05 a.m., in room 334, Cannon House Office Building, Hon. Bob Edgar (chairman of the subcommittee) presiding.

Present: Representatives Edgar, Mica, Dowdy, Evans, Kaptur, Mollohan, Penny, Staggers, Rowland of Georgia, Bryant, Kanjorski, Hammerschmidt, Hillis, Bilirakis, Johnson, and Rowland of Connecticut.

OPENING STATEMENT OF CHAIRMAN EDGAR

Mr. Edgar. Good morning. The subcommittee will come to order. We are meeting this morning to receive testimony on various medical legislative proposals, and also to have a markup. We apologize for the unusual nature of this procedure but the full committee had scheduled its full markup for next week and we wanted to have an opportunity to mark up our legislation.

Today we will hear legislative discussion on H.R. 788, which would encourage recruitment and retention of nurse technicians. The VA employs nursing school graduates as temporary full-time graduate nurse technicians until they are registered as graduate nurses by a State board of nursing. These appointments may not exceed 1 year.

This bill would allow graduate nurse technicians appointments to exceed 1 year, which would mean they would be eligible for Government-sponsored health and life insurance. Current law prohibits such insurance coverage.

The VA also employs nursing school students as student nurse technicians on a part-time basis during school and on a full-time basis during the summer. Current law prohibits reappointment of part- or full-time student nurse technicians after 1 year. H.R. 788 would allow the VA to employ these students until graduation, thus allowing the VA to hire the new graduate nurses upon completion of their education.

H.R. 789, which would extend the 5-year Pilot Contract Program for treatment and rehabilitation of veterans with alcohol or drug dependence or abuse disabilities until September 30, 1988, will also be a subject of this hearing.

Another measure, H.R. 1303, would permit the implementation of the transfer of certain functions from the VA prosthetics center in New York City to a new prosthetics assessment and information center in the Washington, DC, area without waiting to begin the transfer until the beginning of fiscal year 1986, as currently required by law.

H.R. 1818, which would authorize the Administrator to release a limitation on the use of certain real property conveyed by the Administrator to the city of McKinney, TX, will be discussed as well.

Finally, we will look at H.R. 2227, which would authorize the Administrator of Veterans' Affairs to conduct three demonstration projects for the purpose of evaluating the cost effectiveness of providing chiropractic care to veterans.

A draft proposal to provide for participation by more States in the program of grants to States for the construction of State veterans homes will also be discussed.

I would now like to recognize the ranking minority member of the subcommittee, Hon. John Paul Hammerschmidt, for any remarks he may wish to make.

Mr. HAMMERSCHMIDT. Thank you very much, Mr. Chairman.

Due to the rather unusual procedure we are using, I think we need all the time that we can muster here, so I am going to forgo any formal opening statement. I would just say that the bills upon which we will hear testimony this morning, of course, are intended to enhance the Veterans' Administration Medical Program.

In addition to our many professional witnesses we are getting ready to hear, I am pleased to note that we have one of our very distinguished and capable colleagues, Mr. Nichols, with us today, and I am anxious to hear his testimony.

Thank you, Mr. Chairman.

Mr. EDGAR. Mr. Bilirakis.

OPENING STATEMENT OF HON. MICHAEL BILIRAKIS

Mr. BILIRAKIS. Thank you, Mr. Chairman. As always, I am looking forward to the testimony we will be hearing this morning on the various bills and proposals before the subcommittee. Since we will be marking up these bills at the end of the hearing, I think it is important that we have benefit of the views and suggestions of the VA and the veterans' organizations before we make our recommendations on this health care legislation. So, gentlemen, I am pleased to welcome all of you here today.

While all of these bills deal with important health care issues, three of the proposals before us are of particular concern to me as a Representative from the State of Florida.

On April 25, we heard testimony on H.R. 505, the Older Veterans Health Care Amendments of 1985. We are certainly reminded often on this committee on the 5,000 or so veterans moving into the State of Florida every month and I can assure you that many, many of those are older veterans who are in need of medical care from the VA. So our recommendations on H.R. 505 will be most significant to Florida veterans.

In light of this large and growing elderly veteran population in the State, it is ironic that Florida is one of the 17 States which does not have a State veterans home. Therefore, I am also most interested in hearing what our witnesses have to say about H.R. 789 and about the draft proposal to restructure the State Home Construction Grant Program. Obviously, I am keenly interested in learning what changes, if any, are needed to facilitate the earliest possible approval and funding of a State veterans home in Florida.

Mr. Chairman, I'll take no further time now except to say that I look forward to having the opportunity to pose some questions to our witnesses on this issue at the appropriate time. However, I would like to mention that I do have a conflict. I am also scheduled to attend a markup in my Energy and Commerce Subcommittee at 9:45.

Thank you, Mr. Chairman.

Mr. EDGAR. Our first witness will be Hon. Bill Nichols, who is from the Third District of Alabama. We welcome him to the table.

We also want to note as he takes the witness table that he helped us to put together the veterans GI education bill over the last several years and we worked with him on that issue. We are pleased to again hear your testimony.

STATEMENT OF HON. BILL NICHOLS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ALABAMA

Mr. NICHOLS. Thank you, Mr. Chairman, and ladies and gentlemen of the committee. Let me say I appreciate the opportunity this morning to appear before your subcommittee to support proposals to amend the current Federal law to allow for the use of Federal funds to State nursing home grants on a needs basis. You and I have discussed this briefly, Mr. Chairman, and I know some serious thought has been given to it by you and other members of your committee.

A recent Veterans' Administration study estimates that my State of Alabama currently has over 60,000 veterans of World War II. And because of what is anticipated to be migration to the South over the next few years, this figure may expect to double by the 1990's. Alabama is currently some 1,200 nursing beds deficient for veterans needing long-term VA nursing home care. Presently, the Veterans' Administration operates 232 nursing home beds in the State of Alabama. The private sector nursing homes in my State are currently operating at 97 percent capacity, Mr. Chairman and gentlemen of the committee.

I think these numbers clearly indicate the critical need for a State veterans nursing home in my State of Alabama. Recognizing this need, the Governor of my State, Gov. George Wallace—I might add a World War II combat soldier in his own right—the State legislature has already committed the State's 35 percent share of funding, some $2 million in this case, for this project, by October 1986.

The proposed factors in your bill relating to a determination of need in my judgment are most worthy and I am hopeful that you and the members of this distinguished panel may see fit to amend current law to reflect the needs basis.

Alabama, I understand, currently ranks No. 50 on the Veterans' Administration State Home Grant Program list. We have been told that the 65-percent funding by the Veterans' Administration could be anticipated by the year 1990 or beyond. Mr. Chairman, the needy and deserving aged veterans of Alabama are in critical need of this home now, not in 5 or 10 years.

I appreciate the opportunity to make this presentation and I am submitting for the record a more formal statement which more fully outlines my views.

I would be pleased to respond to any questions the committee might have.

[The statement of Hon. Bill Nichols appears at p. 31.]

Mr. EDGAR. Let me just say that we are pleased that you have taken the time to testify today. You do indicate strong support for our provision in the legislation that would set a priority on trying to encourage new States to get involved in the application and process of State veterans homes, where a partnership between Federal and State government has proven itself to be very effective. Thank you for that testimony.

Are there any questions from my colleagues?

Mr. HAMMERSCHMIDT. Mr. Chairman, I don't have any questions, but I want to thank Bill Nichols for his very excellent testimony. I know of his long time interest, of course, in veterans affairs, and also of the continuing contribution he makes on the Armed Services Committee. He knows a lot about armed services personnel, probably as much as anybody in the Congress. So we appreciate your being here, Bill.

Mr. NICHOLS. Thank you, Mr. Hammerschmidt.

Mr. EDGAR. Are there any other questions?

Mr. MOLLOHAN. Mr. Chairman, I don't have any questions but I would like to echo the accolades expressed by Congressman Hammerschmidt about Congressman Nichols. He has been a particularly helpful Member to me in my first 3 years in the Congress. I value his judgment greatly. I must say his testimony here today tracks the experience that I'm having in my district with regard to nursing homes. I appreciate very much his appearing before our committee to offer his expertise and excellent testimony.

Mr. NICHOLS. Thank you.

Mr. EDGAR. Thank you.

Any other questions? Thank you very much, Mr. Nichols, for taking the time today.

Mr. EDGAR. Our next witness will be Dr. John Gronvall, Deputy Chief Medical Director, Veterans' Administration. I know you are accompanied by a few other folks and I hope you will take the time to introduce them to us.

The full text of your statement will be made a part of the record and we would appreciate any summary that you could make at this time.

STATEMENT OF JOHN GRONVALL, M.D., DEPUTY CHIEF MEDICAL DIRECTOR, VETERANS' ADMINISTRATION; ACCOMPANIED BY JOHN MATHER, M.D., ASSISTANT CHIEF MEDICAL DIRECTOR FOR GERIATRICS AND EXTENDED CARE; CARL HUGHES, M.D., ASSISTANT CHIEF MEDICAL DIRECTOR FOR PROFESSIONAL SERVICES; THOMAS PRICE, CHIEF, MANAGEMENT OPERATIONS STAFF; AND AUDLEY HENDRICKS, OFFICE OF THE GENERAL COUNSEL

Dr. GRONVALL. Thank you very much, Mr. Chairman. It is a pleasure to be here. I will just quickly introduce the people with me at the witness table, and I will summarize my statement and would thank you for incorporating it.

Mr. Audley Hendricks at my left is from the General Counsel's Office; Mr. Jack Price from our management support office, Chief of Management Operations. On my right is Dr. Carl Hughes, who is Assistant Chief Medical Director for Professional Service, and then Dr. John Mather, who is Assistant Chief Medical Director for Geriatrics and Extended Care.

Our testimony covers a number of bills and a number of provisions which we support. To open my comment, I will just list those rather than make comment.

We support and favor the adoption of H.R. 788 that would assist us in retaining and hiring graduate nurses and student nurses.

We support and favor adoption of H.R. 1303, that would transfer functions from New York to a new Prosthetics Assessment Center in the Washington, DC area, and we favor adoption of H.R. 1818, that would release land in McKinney, TX.

In regard to H.R. 789, there are a number of provisions—I should comment also that we have submitted a draft bill that would duplicate many of these provisions and, in addition, we favor the adoption of extension of contract authority for Puerto Rico, the Virgin Islands, and the Philippines.

We favor adoption of section 2 of H.R. 789 that would extend the alcohol and drug dependence programs. We favor extension of the State Home Construction Grant Program, and there we prefer a 5-year extension rather than 3, as is in the proposed legislation. Finally, we favor the elimination of the one-third limitation in the State Home Construction Program.

With that, let me then make comments really on only two matters that are before the committee today. The first is the draft proposal that would revise the basis of the State Home Construction Program. At the present time, as you know, the law provides that when the VA finds that a State home construction grant proposal meets the test of law, the proposal is approved and it is funded in order of its receipt as funds become available.

The proposed legislation would make a substantial revision of that approach and establish need as the basis for funding. We believe that this proposed legislation is based on the assumption that the present approach fails to address the VA's need for State homes. In fact, it is our belief that the State Home Construction Program as now constituted, when taken in combination with other activities in our program planning process, the MEDIPP process, and our construction planning process, in fact does address need from the VA's perspective.

It is our judgment that States, in fact, do not submit applications for this program unless there is a need for the program. Even though the VA can provide up to 65 percent of the construction funding, it is the responsibility of the State to provide the remainder and then to operate the facility. That requires then that the State be assured itself that there is a need for the facility.

The State must invest considerable effort and expense in preparing an application, and our concern would be that the revision in the proposed legislation might discourage States from applying if they believe that their application would not be eventually funded because some other State had a higher need.

Therefore, we do not favor adoption of this revised approach to the program. We would prefer, rather, that the present program be fine tuned, and we would be prepared to work with the committee to suggest ways in which a higher priority might be given for need in the program.

The only other comments that I want to make in this opening statement have to do with the draft proposal regarding chiropractic care. You have asked us to comment on the draft legislation that would require three demonstration sites to investigate the cost effectiveness of chiropractic care.

Surely that proposal is based on the assumption that there would then be subsequently established a permanent program if the demonstration was judged to be a success. We have previously testified and continue to take a strong position against the incorporation of chiropractic care as a provided service through the VA health care system. In our view, the provision of chiropractic care through the VA would represent a fundamental change in the function and orientation of our system which we believe is both negative and is, in fact, not needed.

We don't really intend to rekindle the entire debate about the scientific or therapeutic validity of chiropractic, but as we have reviewed the literature, we see little evidence that the chiropractic profession itself has investigated its cost effectiveness and we question why the VA should be asked to undertake such a study.

In closing, I would add that the study of this matter would be complex. We think it would take longer than the 3 years described in the bill. We think it would be more expensive than is suggested, and we think the conduct of the study itself would pose very difficult problems for the VA.

That concludes my summary comments, Mr. Chairman. My colleagues and I would be pleased to respond to any questions that you have.

[The statement of Dr. John Gronvall appears at p. 33.]

Mr. **Edgar**. Thank you very much.

I yield to my colleague, John Paul Hammerschmidt, for questions.

Mr. **Hammerschmidt**. Just a couple of short questions, and then I would like to submit more questions for your response for the record.

Dr. Gronvall, how does the VA assure that the present State Home Construction Grant Program gives priority to those States with the greatest need?

Dr. Gronvall. The present program consists of a review of each application as it is submitted, to assure that it meets the requirements of the law. Once that assurance is gained, the project is placed in order and then is funded in that order once funds become available.

We believe that all of the homes constructed through the program do meet a need; that is part of the review. The only issue is the order of funding which at current is based on the order in which it is submitted in relation to other projects that have been submitted for review.

Mr. Hammerschmidt. Looking at it nationwide rather than on a State-by-State basis.

Dr. Gronvall. Yes.

Mr. Hammerschmidt. Why is the prosthetic center move needed and what problems should it solve?

Dr. Gronvall. This is part of a major reorganization of our entire prosthetics research and patient care program. The relocation of the center will provide new functions and revised functions in the Washington area at a medical center and in a setting where we think the assessment and information will be more effective than was possible in its current setting in New York.

Mr. Hammerschmidt. Well, we appreciate your testimony and your responses. We always appreciate the panelists coming before this committee. I will submit further questions for the record.

Thank you, Dr. Gronvall.

Dr. Gronvall. Thank you.

Mr. Edgar. Are there other questions of Dr. Gronvall? Mrs. Johnson?

Mrs. Johnson. Doctor, in terms of chiropractic care, what is common in the private sector hospital?

Dr. Gronvall. At the present time I am really unaware of any community hospital on which chiropractors function as a member of the medical staff of the hospital, so I am not aware of any community hospital where chiropractic care is given within the hospital.

Mrs. Johnson. Thank you.

Mr. Edgar. Are there other questions?

Dr. Gronvall, can you list out for us which States have taken advantage of the State veterans home program?

Dr. Gronvall. I can't from memory. Dr. Mather is responsible for that program and may be able to.

Dr. Mather. Mr. Chairman, I suggest we provide a detailed response for the record. But overall, there are 34 States that have been active participants in the program.

Mr. Edgar. Of those 34 States, which is the leading State in terms of the number of State veterans homes?

Dr. Mather. At this point in time I believe it is Michigan, but I would have to check that for the record.

Mr. Edgar. Do you know how many homes there are in Michigan?

Dr. Mather. Approximately five, Mr. Chairman.

Mr. **Edgar**. Would you say there are probably no other States that have five homes?

Dr. **Mather**. Mr. Chairman, I don't recall precisely. I will have to provide that for the record.[1]

Mr. **Edgar**. If Michigan were to come up with a sixth home and they would get their application in prior to Mr. Nichols in Alabama, under the present law Michigan would be provided the sixth home before Alabama would be provided the first home; is that not correct?

Dr. **Mather**. Mr. Chairman, I don't think that's correct under our current procedures. They would, in fact, be the last to be received in our office and a determination as to whether their preapplication was suitable would then lead them not coming ahead of Alabama.

Mr. **Edgar**. Would you answer that question again? I didn't understand the answer.

Dr. **Mather**. Our current procedures, Mr. Chairman, would mean that receipt of an application or preapplication from Michigan would put them the last to be funded, so it would not put them ahead of Alabama.

Mr. **Edgar**. But that's the point I'm making. They would be the last to be funded, right?

Suppose they put their application in today. Suppose another State that is not part of the 34 were to put their application in tomorrow. Who would be funded first, Michigan or the State that came in tomorrow that had no veterans homes?

Dr. **Mather**. It depends on the order in which they would come in, Mr. Chairman. We very simply would follow our current procedures and as they come in they would be taken care of when the money is appropriated.

Mr. **Edgar**. So that Michigan would be funded first?

Dr. **Mather**. If it came in ahead of a subsequent State's application.

Mr. **Edgar**. You see, that's the problem, Dr. Gronvall, that we're trying to deal with. We like the fact that Michigan has been aggressive and that they have five State homes. We like the fact that other States have gotten into the program and we hope that other States will also get into it. We want to fully fund it at $35 million a year; in fact, we have some draft amendments that will authorize a little higher level of expenditure. But we hope that the actual appropriation will be at least $35 million a year. We need to figure out some way to, at the same time, encourage States to be part of the State home program, not to discourage other States from either applying because they have a 7-, 8-, 9-, 10-year wait, or because they simply were not first in getting their applications in.

It is also conceivable that there would be States that have surpluses in their budgets which might designate a certain percent of that surplus for State veterans homes, trying to secure the leverage of the 65-percent Federal dollars, which would go through the application process and which would be able financially to get their applications in sooner than other States that have the same veteran need but not the same surplus in their budgets. That's why we have tried to devise a procedure.

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[1] See p. 10.

The discussion draft that we sent you on the State nursing home grant program would have required prior congressional authorization for each grant. The bill that was introduced yesterday does not include that provision. Instead, it authorizes grants in the amounts of $40 million in 1986, $45 million in 1987, and $50 million in 1988. We would anticipate having you put your list together based on that.

How does this affect your reservation about the proposal?

Dr. **Gronvall**. As you can see from our more expanded formal statement, we had expressed concern about the requirement for prior approval, so the elimination of that provision I think does away with one of the provisions in the draft bill that we had taken exception to.

Let me expand my comments a little bit to respond to a number of things that you said. I think we view the State home program primarily as a State responsibility, but as we plan for meeting the needs of veterans, we take into account what the State has done and plans to do as we plan the deployment of VA facilities. So in that sense we view the State home program as primarily a State responsibility, but working in collaboration with VA efforts itself in such a way that the total program of medical care for veterans we believe is adjusted to the need as defined by the VA on a nationwide basis.

I should also comment that when an application is received from a State it is reviewed to ensure that there is a need. For example, if the proposal would result in the State having more than 2½ nursing home beds per 1,000 veterans in the State, we require a specific justification that gets reviewed as to why a higher level of nursing home beds ought to exist in the State home program in any particular State. So we believe we take need into account in that way.

As I mentioned but could perhaps expand on a little bit, it is our view that, over time, if the State has assurance that their application, once it is judged to meet need, will, in fact, be funded—although it may be a long timetable—we believe that provides a strong incentive for States to participate. Our preferred solution over the past years has been that the total program be funded at a higher level, which would shorten the backlog, and that that would be the way to accomplish a more desirable ability to respond to initiatives by the States.

Mr. **Edgar**. Let me correct the record and indicate that it is Oklahoma that has the five State veterans homes. Michigan only has two. We have the list here that we can put at this point in the record so that you can clearly see.[1]

The question is, Oklahoma, with a State home in Ardmore, Clinton, Norman, Sulphur, and Talihina, they get 65 percent of the funding to construct those nursing homes. They get 25 to 30 percent of the per diem cost of caring for those veterans in those homes. That's important to the State of Oklahoma. It may also be that the Veterans' Administration—I don't know how many of the veterans homes there are in Oklahoma, and I don't know how many nursing homes in the private sector they have in Oklahoma, but it seems strange to me that one State has five and States like New York, New Jersey, have two, one, and are not in a position of having the number.

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[1] Retained in committee files.

If you would take the population of Oklahoma versus the population of California, the population of Pennsylvania, the population of other States, in terms of density of veterans, my guess is that you would have far more.

I understand the reasons for letting the States use it as a State program, but there is a Federal responsibility. If you have a limited number of dollars, namely, in this case, $35 million, and you've got to spend those $35 million as carefully as you can, the fact that Alabama comes in and has no home, or another State comes in and has no home, it seems to me it would be fair, if the criteria is met for that application, that before Oklahoma receives its sixth veterans home, that Alabama would be funded, or some other State that has none would be funded.

Now, I'm speaking with some jeopardy to Pennsylvania because we have a request for a third veterans home in Pennsylvania, but I think—and I'll even say this—that even before the third veterans home in Pennsylvania is built, some consideration for some areas of the country or States that have none ought to be given, if we're going to share this limited Federal commitment with the State government. That's what we're trying to address in a priority setting here.

Dr. **Gronvall.** One thing that we might submit for the record might contribute to that deliberation. I think it might be useful for you to have the list by State of both the State homes that now exist, with the number of beds, and the projections in terms of State homes in the funding cycle, as well as VA homes in those States, and then a comparison with the total number of veterans present and projected. We would be happy to supply that.

Mr. **Edgar.** That would be helpful.

[The referred to list follows:]

[Subsequently the Veterans' Administration provided the following:]

On July 1, 1985, 34 States were operating 47 State Homes and three annexes; 31 States were operating 42 domiciliaries with 7,509 authorized beds, 28 States were operating 42 nursing homes with 9,718 beds, and six States were operating seven hospitals with 689 beds. The authorized bed capacity for each State is identified on a list following this statement.

At the time of final budget formulation in December 1984, there were 65 preapplications and applications for grants on hand totalling $151 million. Of these, the first 26 grant requests totalling $67 million are expected to be funded with the 1985 and requested 1986 appropriations. This would leave 39 grant requests totalling $84 million unfunded. A list of eligible preapplications and applications as of December 1984 follows this statement.

With the appropriation of $34.5 million in FY 1985 and requested appropriations of $22 million for FY 1986 and the out years, all the applications on the list will not be funded until 1991.

The estimated total veteran population as of March 31, 1985, was 27.8 million, the projections[1] of veterans population for 1990, 1995, and 2000 show a declining total population but an increasing aging population. The estimate and projections for each State are identified on a list following this statement.

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[1] Published April 29, 1983. Office of Reports and Statistics, Veterans Administration.

STATE HOME PROGRAM—AUTHORIZED BED CAPACITY

[Locations/Number of States, July 1, 1985]

State home (47&3 annexes/34)	DOM (2/31)[1]	NHC (42/28)[2]	Hosp (7/6)
1. Arkansas: Little Rock	150		
2. California: Yountville	749	769	66
3. Colorado:			
Florence		120	
Homelake	135	30	
4. Connecticut: Rocky Hill	754		350
5. Georgia:			
Augusta		192	
Milledgeville	288	252	
6. Idaho: Boise	134	80	
7. Illinois: Quincy	346	511	50
8. Indiana: Layfayette	186	462	
9. Iowa: Marshalltown	113	692	26
10. Kansas: Fort Dodge	312	88	
11. Louisiana: Jackson	100	136	
12. Maine: Augusta		120	
13. Maryland: Charlotte Hall	126		
14. Massachusetts:			
Chelsea	305	68	166
Holyoke	50	259	27
15. Michigan:			
Grand Rapids	175	588	
Marquette	87	58	
16. Minnesota:			
Minneapolis	195	346	
Hastings	200		
17. Missouri:			
St. James	48	200	
Mount Vernon		104	
18. Montana: Columbia Falls	100	66	
19. Nebraska:			
Grand Island	35	414	
Norfolk, Annex	34	127	
Omaha, Annex	33	159	
Scottsbluff, Annex	118		
20. New Hampshire: Tilton		100	
21. New Jersey:			
Menlo Park	40	348	
Vineland		300	
22. New York: Oxford	118	124	
23. North Dakota: Lisbon	159		
24. Ohio: Sandusky	*844	300	
25. Oklahoma:			
Ardmore	120	100	
Clinton	47	156	
Norman	13	242	
Sulphur	30	142	4
Talihina		162	
26. Pennsylvania:			
Erie	100	75	
Hollidaysburg	179	202	
27. Rhode Island: Bristol	128	295	
28. South Carolina: Columbia		150	
29. South Dakota: Hot Springs	275	50	
30. Vermont: Bennington	24	135	
31. Washington:			
Orting	76	126	

STATE HOME PROGRAM—AUTHORIZED BED CAPACITY—Continued

[Locations/Number of States, July 1, 1985]

State home (47&3 annexes/34)	DOM (2/31)[1]	NHC (42/28)[2]	Hosp (7/6)
Retsil	237	161	
32. West Virginia: Barboursville	195		
33. Wisconsin: King	28	709	
34. Wyoming: Buffalo	123		
Total	7,509	9,718	689

*(490 OP.)

ELIGIBLE PREAPPLICATIONS AND APPLICATIONS FOR GRANTS FOR CONSTRUCTION OF STATE EXTENDED CARE FACILITIES

[Pending approval, dollars in thousands December 17, 1984]

FAI Number and State (locality)	Project	Estimated grant request
24–003: Maryland (Charlotte Hall)	(3d phase—126 dom/NH beds)	$3,047
24–004: Maryland (Charlotte Hall)	(4th phase—126 dom/NH beds)	5,298
08–007: Colorado (Rifle)	New State home—100 NHC beds	2,426
42–006: Pennsylvania (Hollidaysburg)	Boiler plant modifications	597
17–007: Illinois (Quincy)	Renovation Andrew	351
17–008: Illinois (Quincy)	Energy conservation	117
17–009: Illinois (Quincy)	Fire safety	111
26–002: Michigan (Grand Rapids)	Replacement Mann—226 NH beds	11,003
06–008: California (Yountville)	Hospital addition—56 beds	6,254
06–009: California (Yountville)	Remodel dom—C	2,384
06–010: California (Yountville)	Remodel dom—A	1,808
06–014: California (Yountville)	Rem. sec. D dom-life safety	1,853
26–003: Michigan (Marquette)	New State home 155 D/N	2,652
34–009: New Jersey (Paramus Phase I)	New State Home—114 bed NH	6,108
34–010: New Jersey (Paramus Phase II)	New State home—100 bed NH	5,054
34–011: New Jersey (Paramus Phase III)	New State home—100 bed NH	5,131
28–001: Mississippi (Jackson)	New State home—150 bed NH	4,388
30–002: Montana (Columbia Falls)	50—bed NH wing	1,203
25–029: Massachusetts (Chelsea)	Elevators	78
25–030: Massachusetts (Chelsea)	Renovations	76
06–012: California (Yountville)	Remodel hospital ward 1A	118
37–N003: Pennsylvania (Hollidaysburg)	Renovations-NHC-grant increase	99
37–N004: Pennsylvania (Hollidaysburg)	Renovations-dom-grant increase	191
13–004: Georgia (Milledgeville)	150 bed NH	5,902
27–006: Minnesota (Hastings)	Grant increase	474
17–010: Illinois (Quincy)	Life safety-fire alarm	144
42–008: Pennsylvania (Hollidaysburg)	Renovation-Sommer-225 NH beds	4,091
06–013: California (Yountville)	Rem. sec. B to NH-life safety	2,179
06–011: California (Yountville)	Cooling plant and piping	1,359
06–015: California (Yountville)	Rem. sec. E life safety	1,729
06–016: California (Yountville)	Rem. hospital support service	1,300
06–017: California (Yountville)	Rem. nursing home	1,557
06–018: California (Yountville)	Rem. sec. F—handicapped	1,299
06–019: California (Yountville)	Rem. workshop-sprinkler	98
36–002: New York (Long Island)	New 350 bed NH	14,625
06–020: California (Yountville)	Rem. sec. H Dom-fire and safety	1,105
06–021: California (Yountville)	Rem. sec. J Dom-Fire and safety	1,105
06–022: California (Yountville)	Rem. sec. K Dom-fire and safety	1,105
06–023: California (Yountville)	Rem. sec. L Dom-fire and safety	1,105
06–024: California (Yountville)	Rem. wings 1C–D, 2C–D, 3C–D NH-fire and safety	1,557
05–002: Arkansas (Little Rock)	Conversion 70 dom beds to NH	195
42–009: Pennsylvania (Hollidaysburg)	Renovate dietary building	1,800
44–003: Rhode Island (Bristol)	Domiciliary renovation	1,138
12–001: Florida	New State home 150-bed dom	2,730

ELIGIBLE PREAPPLICATIONS AND APPLICATIONS FOR GRANTS FOR CONSTRUCTION OF STATE EXTENDED CARE FACILITIES—Continued

[Pending approval, dollars in thousands December 17, 1984]

FAI Number and State (locality)	Project	Estimated grant request
39–002: Ohio (Sandusky)	Grant increase	$221
29–004: Missouri (St. James)	Replace NHC unit-100 beds	2,420
40–009: Oklahoma (Clinton)	New 50 bed NHC unit	965
16–002: Idaho (Boise)	Renovate dom wing into Dom/NHC beds	1,105
39–011: Ohio (Sandusky)	Add 100 NHC beds, secrest	2,918
06–025: California (Yountville)	Remodel wards 2–3 E	813
06–026: California (Yountville)	Remodel annex I	1,170
06–027: California (Yountville)	Remodel annex II	1,170
06–034: California (Yountville)	Remodel ground & 1st floor	650
06–028: California (Yountville)	Remodel dom sec. G & LSC	1,463
54–003: West Virginia (Pruntytown)	Remodel school for 202 NHC phase I	2,961
54–004: West Virginia (Pruntytown)	Remodel school for NHC phase II	2,602
06–031: California (Yountville)	Renovate kitchen & dining room	195
06–032: California (Yountville)	Renovate hospital food service	195
06–029: California (Yountville)	Renovations-storage areas	195
06–033: California (Yountville)	Renovations-sprinkler system	98
05–035: California (Yountville)	Renovations-administration building	98
39–003: Ohio (Sandusky)	New 300 bed dom	9,223
39–010: Ohio (Sandusky)	New 200 bed dom	5,188
01–001: Alabama (Alexander City)	New 150 bed NHC	4,615
29–005: Missouri (NW)	New 150 bed NHC	5,850
Total		151,059

ESTIMATED VETERAN POPULATION IN THE UNITED STATES, BY STATE

STATE	FISCAL YEAR—			
	1985	1990	1995	2000
Total	27,818,900	26,936,100	25,676,200	24,135,600
Alabama	436,900	433,900	422,700	405,200
Alaska	47,800	42,600	39,300	36,000
Arizona	390,300	409,700	407,200	394,200
Arkansas	272,000	276,800	272,300	262,400
California	2,936,400	2,791,100	2,629,100	2,447,000
Colorado	398,200	392,100	378,500	360,400
Connecticut	404,100	380,900	354,600	325,700
Delaware	76,000	72,700	68,800	64,300
District of Columbia	61,900	55,000	50,600	46,500
Florida	1,420,700	1,503,900	1,504,100	1,462,000
Georgia	633,700	630,000	614,700	590,600
Hawaii	96,300	91,500	87,200	82,300
Idaho	122,300	123,500	120,800	116,000
Illinois	1,309,200	1,213,700	1,122,500	1,027,500
Indiana	670,000	643,600	611,700	575,000
Iowa	347,700	331,700	313,300	292,600
Kansas	293,400	281,400	266,700	249,700
Kentucky	400,600	390,500	374,300	353,500
Louisiana	448,600	441,600	426,800	407,000
Maine	152,700	151,200	146,800	140,600
Maryland	532,700	499,300	467,100	432,400
Massachusetts	699,000	651,000	603,200	551,400
Michigan	1,097,400	1,041,700	981,900	914,800
Minnesota	516,700	498,300	474,200	446,000
Mississippi	243,300	239,600	231,500	220,300
Missouri	640,100	622,500	595,500	562,400
Montana	106,800	104,600	100,500	95,200

ESTIMATED VETERAN POPULATION IN THE UNITED STATES, BY STATE—Continued

STATE	FISCAL YEAR—			
	1985	1990	1995	2000
Nebraska	186,800	179,200	170,200	159,700
Nevada	140,500	147,000	145,500	140,000
New Hampshire	138,900	141,200	138,700	133,900
New Jersey	902,400	843,400	778,900	708,400
New Mexico	162,400	163,800	160,900	155,400
New York	1,878,200	1,703,700	1,555,300	1,407,500
North Carolina	656,400	643,000	619,000	585,700
North Dakota	67,400	64,100	60,800	57,100
Ohio	1,357,300	1,287,700	1,212,600	1,129,700
Oklahoma	395,500	393,400	380,400	362,100
Oregon	403,500	409,800	401,500	387,000
Pennsylvania	1,564,100	1,487,400	1,393,900	1,287,500
Rhode Island	123,400	116,900	109,300	100,800
South Carolina	350,400	346,100	336,600	321,500
South Dakota	78,500	75,900	72,700	68,800
Tennessee	544,000	541,700	526,200	503,000
Texas	1,734,300	1,741,700	1,702,700	1,639,900
Utah	154,500	152,600	146,700	139,000
Vermont	64,100	64,200	62,900	60,600
Virginia	653,000	623,700	591,100	533,200
Washington	632,400	639,800	625,900	602,100
West Virginia	241,200	236,400	227,500	215,800
Wisconsin	567,100	550,600	524,500	492,300
Wyoming	67,700	68,300	66,400	63,700

Mr. EDGAR. Are there any other questions?

Thank you very much for your testimony this morning. We will submit a few questions for the record and, without objection, they will be sent to you. We would appreciate your response.

Our next witness will be Mr. Dennis Cullinan, deputy director, National Legislative Service, Veterans of Foreign Wars.

STATEMENT OF DENNIS M. CULLINAN, SPECIAL ASSISTANT, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. CULLINAN. Mr. Chairman and members of the subcommittee, on behalf of the Veterans of Foreign Wars of the United States, I would now thank you for the privilege of appearing before this distinguished subcommittee so that we may present our views with respect to H.R. 788, 789, 1303, and 1818.

H.R. 788, introduced by you, Mr. Chairman, would allow for the appointment by the Veterans' Administration of temporary full-time nurses who will be pursuing graduate nursing degrees to exceed 1 year. It is our opinion that this would enhance the Department of Medicine and Surgery's ability to both recruit and retain the requisite highly skilled nursing personnel needed to provide first rate health care to veterans. The Veterans of Foreign Wars, therefore, supports the passage of this bill.

Also under consideration at this time is H.R. 789, the Veterans' Health Programs Extension Act of 1985, introduced by Chairman Edgar for himself and Messrs. Mica and Lehman, which would, among other purposes, extend the Administrator's authority to contract for care, treatment and rehabilitative services for veterans suffering from alcohol or drug related disabilities until September 30, 1988. The VFW is, in the main, supportive of enactemnt, provided that it not in any way compromise the VA's own ability to properly and compassionately provide for the health needs of this Nation's deserving veterans.

We do support section 3 of this bill, which would extend for 4 years the matching grants to States to provide facilities for medical and domiciliary care for veterans.

The next bill for consideration is H.R. 1303, introduced by Chairman Edgar. This would permit the transfer of functions of the Technology and Performance Evaluation Section and the Information and Education Service at the Veterans' Administration Prosthetics Center in New York, NY, to a new prosthetics assessment and information center in the vicinity of Washington, DC, without regard to the congressional notice and wait requirements of 38 U.S.C. 210.

Inasmuch as we believe this would greatly enhance the quality of medical care afforded disabled veterans, the VFW strongly supports the expeditious enactment into law of H.R. 1303.

The final bill to be considered at this hearing, H.R. 1818, introduced by Congressman Armey, would release the limitation to recreational purposes only on property conveyed by the Administrator of Veterans' Affairs to the city of McKinney, TX, on May 5, 1965. We have no objections to the passage of this bill.

Mr. Chairman, this concludes my testimony. I will be happy to answer any questions you may have.

[The statement of Dennis Cullinan appears at p. 53.]

Mr. **Edgar**. Thank you very much for your testimony.

Are there any questions of this witness? Thank you very much.

Mr. **Cullinan**. Thank you, Mr. Chairman.

Mr. **Edgar**. Our next witness will be Mr. Frank DeGeorge, associate legislative director, Paralyzed American Veterans.

Thank you for coming to testify today. The full text of your statement will be made a part of the record. We ask you, if you would, to summarize at this point.

STATEMENT OF FRANK DeGEORGE, ASSOCIATE LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA

Mr. **DeGeorge**. Good morning, Mr. Chairman.

For the purpose and essence of time, we would simply like to submit our statement for the record with no further comment.

Mr. Edgar. Without objection, it will be made part of the record.

[The statement of Frank DeGeorge appears at p. 56.]

Mr. **Edgar**. Thank you very much.

Our next witness will be Mr. David Gorman, Assistant National Legislative Director for Medical Affairs, Disabled American Veterans.

Without objection, the full text of your statement will be made a part of the record. We would appreciate any summarization that you might make at this point.

STATEMENT OF DAVID W. GORMAN, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR FOR MEDICAL AFFAIRS, DISABLED AMERICAN VETERANS

Mr. GORMAN. Thank you, Mr. Chairman. Once again, it is a pleasure to appear before this subcommittee.

My remarks will be brief because of the nature of the legislation we have before us for consideration today.

H.R. 788, which would alter the VA's authority to hire nurses beyond the 1-year limitation in the current statute serves in our opinion simply as a recruitment and retainment incentive and we certainly favor enactment of this provision.

Section 2 of H.R. 789 would extend the authority for furnishing care for the treatment and rehabilitation for alcohol and drug related dependencies or disabilities. We have no objection to the enactment of this, measure, Mr. Chairman.

Section 3 of H.R. 789 would extend by 4 years the granting of funds to State homes. Because of our interest in this program and our advocacy of it as a cost-saving measure to the Government, we certainly support that.

Mr. Chairman, the one-third limitation has been suggested by the VA to be one problem in the appropriation of funds to State homes. If as they suggest that is correct, we certainly would have no objection to the removal of that one-third limitation from current law.

As far as H.R. 1303, Mr. Chairman, which was introduced by yourself, this measure would permit the administrator to effectuate an administrative transfer or reorganization of employees from New York to an area in Washington, DC. Because of the DAV's longstanding interest in the reorganization of prosthetics, which we worked very closely together with the PVA, with the Veterans' Administration, we certainly favor the enactment of this provision because we think it will certainly tend to expedite that total reorganization plan.

Mr. Chairman, I think my written statement details in more depth our feelings and positions on these various bills, and this will conclude my testimony.

[The statement of David Gorman appears at p. 63.]

Mr. EDGAR. Thank you very much for your testimony.

Are there any questions for this witness?

Mr. HAMMERSCHMIDT. Mr. Chairman, I don't have any questions, but I want to thank Mr. Gorman. Of course, we are always interested in the testimony from the DAV and we appreciate him being here.

Mr. GORMAN. Thank you very much.

Mr. EDGAR. Thank you, and thank you for taking the time to put your statement together.

Are there any other questions? Thank you.

Our next witness will be Mr. Paul Egan, deputy director, National Legislative Commission, and Mr. Rodney Kirk, assistant director, National Veterans Affairs and Rehabilitation Commission, The American Legion. Gentlemen, we are pleased to have you here this morning and the full text of your statement will be made a part of the record, without objection.

You may proceed.

STATEMENT OF PAUL S. EGAN, DEPUTY DIRECTOR, NATIONAL LEGISLATION COMMISSION, THE AMERICAN LEGION; AND RODNEY S. KIRK, ASSISTANT DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION

Mr. **Egan**. Thank you very much, Mr. Chairman.

Rod Kirk is a brand new Assistant Director of our Veterans Affairs and Rehabilitation Commission. I will just take an opportunity to introduce him to you. He will summarize our remarks.

Mr. **Edgar**. Thank you. We want to also welcome Mr. Kirk. I believe this is the first time you have had an opportunity to testify before our committee.

Mr. **Kirk**. That's correct, Mr. Chairman.

Mr. **Edgar**. Don't be frightened. We won't do anything aggressive. [Laughter.]

STATEMENT OF RODNEY S. KIRK

Mr. **Kirk**. It is a personal pleasure for myself to be here. The American Legion is, of course, as always, appreciative of this opportunity to present to this subcommittee its views on the following bills: H.R. 788, H.R. 789, H.R. 1303, and H.R. 1818.

H.R. 788 is a bill to amend title 38, United States Code, to enhance recruitment and retention of graduate and student nurses by the Veterans' Administration. This appears to be a categorical change in the intent of the second sentence of subparagraph (3) of section 4114(a) of title 38. We are advised by VA DM&S nursing service it is expected this change will enhance the ability of VA to recruit and retain needed nursing professionals in the Department.

Since the American Legion is supportive of all efforts to strengthen the professional services of the Department of Medicine and Surgery, we will express support for this bill.

H.R. 789 is a bill to amend title 38, United States Code, to extend certain expiring veterans health care programs, and for other purposes. Section 620(a) of the title concerns VA programs for treatment and rehabilitation for alcohol or drug dependence or abuse disabilities.

As originally enacted, it was labeled a pilot program by Public Law 96-22. Enough experience has been accumulated by now that it should no longer be labeled a pilot program. We do note the bill will place a time limit on the extension of VA authority to enter into contractual arrangements with halfway houses, therapeutic communities, psychiatric residential treatment centers, and other community-based treatment facilities for veterans suffering from alcohol or drug dependence or abuse.

We presume the time limit is intended to afford the oversight committees the opportunity to monitor the results of programs the VA may develop that utilize the resources of community-based agencies. We commend this provision and we encourage the subcommittee to pay close attention to VA's efforts in this field of treatment for alcohol and drug abuse. We believe there should be clearly a visible intent of the subcommittee to evaluate the effectiveness of the VA's efforts.

VA deserves much credit for the fact that it began to help veterans with alcohol and drug problems before either private sector or community agencies were into this type of health care. VA has been involved in the development of various treatment modalities and technologies that are currently being used. We believe many of them are quite effective and are doing much good for veteran patients.

All that being so, at the same time we believe the activities of the VA in this field do need to be monitored consistently to ensure the effectiveness of what is being done. The reason for this position is that there is still quite a lot of experimentation being done in alcohol and drug treatment. If some of the providers are not monitored, they may introduce unproven treatment program that may have no significant ability to actually help patients.

We believe the VA shold now be focusing its efforts on those programs that have genuine possibilities of helping those veterans who have alcohol and drug problems. With all that is being done, it seems to us we should begin to see, demographically, some measurable results in the effort to contain and alleviate the general problems of alcohol and drug abuse.

With those provisos, we certainly do support the intent of H.R. 789, including that section calling for extension and improvements in the VA's State home construction grant programs.

H.R. 1303 is a bill that has the purpose of enabling the VA Department of Medicine and Surgery to transfer from New York to the Washington, DC, area the Technology and Peformance Evaluation Section and the Information and Education Service located at the Prosthetic Center in New York. A new Prosthetics Assessment and Information Center will be established in the vicinity of the Washington, DC, area.

We are aware that VA has been in the process or reorganizing the entire prosthetics service program to resolve problems that have developed over a period of years. Prosthetics is most certainly one of the most important aspects of VA health care, given the clientele served. We will be supportive of efforts to reach the goals that have been established for the service.

H.R. 1818 is a bill to authorize the Administrator of Veterans' Affairs to release a limitation on the use of certain real property conveyed by the Administrator to the city of McKinney, TX. We note the land in question was deeded to the city in 1965, and we know of no reason to oppose the intent of this bill.

Mr. Chairman, that concludes my statement. I will be happy to respond to any questions.

[The statement of Rodney Kirk appears at p. 70.]

Mr. **Edgar**. Thank you very much. Again, thank you for coming and preparing testimony for our committee. We appreciate your work in this area and we look forward to having you before our committee in the future.

I yield to my colleague, John Paul Hammerschmidt.

Mr. **Hammerschmidt**. I want to join our chairman, Mr. Kirk, in thanking you for your fine testimony. You're in real good hands there with Paul Egan at your side. We found, despite him being a Harvard man, he's kind of a down-to-earth fellow.

Thank you very much.

Mr. **Egan**. Thank you, too.

Mr. **Edgar**. I didn't know he was from Harvard. How come none of the legislative directors are from Lycoming College in Williamsport, PA? [Laughter.]

Are there any questions of these witnesses? Thank you very much for your testimony.

Mr. **Kirk**. Thank you, Mr. Chairman.

Mr. **Egan**. Thank you.

Mr. **Edgar**. Our last witness will be Mr. Jack Dack, chairperson, legislative committee, National Association of State Veterans Homes. He will be accompanied by several other persons.

Mr. Dack, we appreciate your coming this morning. The full text of your statement will be made a part of the record. It would be helpful if you would introduce those who are with you this morning and summarize your statement, if possible.

STATEMENT OF JACK DACK, CHAIRPERSON, LEGISLATIVE COMMITTEE, NATIONAL ASSOCIATION OF STATE VETERANS HOMES; ACCOMPANIED BY HARRY WARREN, SECRETARY TREASURER; FRED TRAILL, COMMANDANT, GRAND RAPIDS, MI VETERANS HOME; AND JERRY STEWART, ADMINISTRATOR, SULPHUR, OK VETERANS CENTER

Mr. **Dack**. Thank you, Mr. Chairman.

On my left is Mr. Harry Warren, secretary treasurer, Nebraska; on my far right is Fred Traill, commandant of the Michigan Veterans Home in Grand Rapids; on to my immediate right is Jerry Stewart, administrator of the Oklahoma Veterans Center in Sulphur, OK.

Mr. Chairman, members of the Subcommittee on Hospitals and Health Care, we in the association appreciate the opportunity to present our thoughts and concerns pertinent to the discussion draft of April 16, 1985, to amend title 38, United States Code, to provide for participation by more States in the program of grants to States for construction of State veterans homes.

Our association, in conjunction with the Veterans' Administration, for years has been active in working with States who have demonstrated an interest in developing State veterans homes. This is a slow process within a State, requiring anywhere from 5 to 15 years before it becomes a reality.

For example, we worked with the State of Florida in the early seventies concerning establishing a home. Florida is now awaiting funding. Presently, there are 34 States with homes, one State developing a home at this time, three new States awaiting funding, four States who have expressed some interest, and eight States who at this time have not expressed interest. Three States in the past—Alaska, Hawaii and Utah—have considered establishing a home but have taken no action to date.

We in the association commend the committee for their interest in wanting to further the expansion of the State Home Program. Careful analysis of the proposed method as expressed in the discussion draft, however, convinces us that the program will suffer through this legislation. It will conceivably deter States not now in the program from starting, and may well seriously inhibit States now in the program from expanding facilities and services to meet their perceived needs.

Our concerns are, No. 1 that the ranking of submitted grant applications relative to other applications received by the Administrator of the Veterans' Administration introduces an added layer of prioritization on top of existing mechanisms established by State clearinghouses, certificate-of-need requirements, MEDIPP processes, and other similar requirements now in place. The existing processes already in most States do now take into account the projected number of veterans who may apply for admission into a facility, the presence of VA facilities within State boundaries, and MEDIPP plans for use of those facilities and the number and utilization of community-based facilities.

No. 2, the language relative to annual listing by the Administrator and subsequent approval by the joint House and Senate Veterans' Affairs Committees will result in further delay and could put the States in an untenable position relative to funding State home projects. Under the current "first-come, first-served" system, a State can estimate when it may come to the top of the list and develop its plans to coincide the flow of State funds with the availability of Federal funds.

The process of bidding a project and the subsequent award of VA funds is a final step prior to starting project construction. It is our understanding that implementation of the process contained in this draft would require the State to pursue the costly development of a project through the bid phase, one, entirely on its own funds and initiative, and two, without any assurance if or when VA funds would be forthcoming unless you intend to fund all projects.

We have not been able, in the brief time available to develop this testimony, to find any State whose legislature is willing to occupy such a "limb-sitting" position. Further, a project bid, once received, is valid only for a 30- to 60-day time span. We cannot perceive a mechanism which would accommodate the steps outlined in 5035(b) and 5033 (a) and (b) within the bid time limitations.

We emphasize that it is the very predictability of VA funding which has supported recent State efforts to renovate, convert, or expand State homes to meet the needs of the aging veteran population. To take away this predictability of funding is to destroy State interest and the ability to participate in this vitally important construction process.

Not all State home projects result in the creation of new beds. From 1966 through 1984, 34 States received grants for 169 projects, 115 of which were for correction of life safety and construction standard deficiencies, as well as programmatic changes. How would these projects, which have met demonstrated need, fit into the "relative need" determination required by the Administrator?

Public Law 88-450, enacted in 1964, put the State veterans homes into the nursing care delivery system and established the basis of the "first come, first served" method of awarding VA construction funds. The existing priority system has proven itself equitable, fair, and predictable. The 34 States in the association and the

VA program administrators have, on many occasions, attempted to find a better method for fund distribution without an acceptable alternative being developed.

We again respectfully suggest that the most equitable method of encouraging expansion of the State home program to meet the long-term health care needs of America's aging veterans is for Congress to appropriate program funds which more adequately match the list of eligible preapplications. In this manner, desirable, equitable expansion of this proven cost-effective alternative to VA service can occur in an expeditious manner.

Thank you for your attention and the opportunity to testify on this important issue. Mr. Chairman, we appreciate your past and continuing support of the program.

[The statement of Jack Dack appears at p. 75.]

Mr. **Edgar**. Thank you very much for your testimony.

First I would like to congratulate the State home group, those of you who are here and those who represent the other 34 States, which are involved. I happen to think that the State veterans home program is one of the most cost efficient and effective programs that we have, that it does work. I think we have to keep an eye on the per diem cost which seemed to slip with the cost of living. I am looking forward to next year when we can address that issue again, to make sure the Federal share remains at a level that is appropriate, while the State provides the lion's share of that day-to-day care for the veteran in a nursing home or domiciliary. You do an excellent job.

I am a bit disturbed at your reluctance to accept or to come up with an merit selection or priority setting. First of all, it seems to me there are 16 other States who you would like to have join your association. It is our hope that those 16 States could come into the framework without waiting for another 6 or 7 years of funding.

Second, you know the commitment of this particular committee in doubling the funding from $18 million to $35 million last year, restoring the cut that was made by the administration in their budget, continuing it at $35 million; you know our commitment to try and accelerate the funding of the projects.

But I would hope that you might appreciate our dilemma in terms of trying to figure out a fair way. David Stockman, over at the Office of Management and Budget, when he is able to take $13 or $14 million out of this program and think of it as savings, will come back to us and say "Well, what's your priority?" When we say, "Well, it's just a first-come, first-served basis", he then begins to question that and asks, I think legitimately, what about the need and what is the basis of that first-come, first-served process.

We have attempted in this legislation to find a fair way of dealing with this issue without hampering those who already have their applications in. I realize why many of you would be opposed to changing a system that you think is working fairly. But from the vantage point of the Chair of this committee, it seems to me we have heard enough concern in testimony from States that have none or one and other States that are in the pipeline for three, four and five homes, it seems to me there is a way we could resolve this while protecting and grandfathering those projects that have already been put in the pipeline.

How do you react to my statement at this point, after praise? [Laughter.]

Mr. DACK. Well, Mr. Chairman, of course we feel strongly that the first-come, first-served approach has worked well for 20 years and it's a clean program. However, I think there might be a misinterpretation when we talk about four or five homes in a State, that those are all new homes. They are not all new homes. For example, my colleague from Oklahoma: Oklahoma has not built one new home yet, but they have taken facilities and renovated those facilities to meet criteria established by the Veterans' Administration to provide care. So a lot of our projects and a lot of our State's homes are a result of the State providing for a State veterans home program through the utilization of already built facilities that need remodeling and renovating.

Mr. EDGAR. Mr. Dack, just to clarify, I understand that for Oklahoma, and I understand it for Pennsylvania, because we have done the same thing. We have renovated at Hollidaysburg and at Erie existing facilities, and we upgraded those facilites. That is great. I am proud of Oklahoma and I'm proud of Pennsylvania and I am proud of your work in your States.

All I'm saying is that in the State of Florida they have some homes that could be upgraded, and they have some facility needs that are there. The State of Alabama has facilities that can be upgraded and they have some needs. It is not a matter of putting down or being negative to what you have already done.

My guess is that if you have a really good entrepreneur in the State home program, who has the ear of the Governor and the State legislature in a State, you can adequately show how this particular leveraged program is not only good for the veterans but is good for economic development in the region, it's good for renovation, and with just a little bit of State and local resources, you can leverage 65 percent of the renovation by the Federal Government, and you can leverage a certain amount of the day-to-day care for these veterans. And that's great.

The problem that I see—and you talked about 20 years of experience—is that we're 20 years later. We now have 34 States in the system. The question that we ask is how do we get the other 16 States in the system, and then as we grow in this program at $35, $40, or $50 million a year beyond the year 2000, how do we make sure that there is some equity across the country in the distribution of these homes so that the entrepreneurs and the good advocates for this program in Oklahoma don't have ten 10 years from now—and I would congratulate them for having 10—and those States that haven't had the experience or don't have the kind of advocates that you are simply still waiting on some imaginary list to, in fact, get their place, or a State that doesn't have the kind of advocacy that you can share would simply lag behind and not participate.

Mr. DACK. I think, Mr. Chairman, it appears to me then that the money that is going to be available to the program then would have to be divided up if you would want to get the other States involved.

The predictability of this program is extremely vital to any of the States coming in. I think it has not been the process of awarding the grants on a first-come, first-served basis or any other way. It has been, I think, the problem of inadequate funding of the program.

Mr. **Edgar**. Suppose you would have come back to us and said, "Look, let's fund $30 million for a first-come, first-served basis, and let's put $5 million aside each year, and every year for the next 16 years let's add an additional State, so that at the end of next year we have bumped up to the top of the list a State or a priority area that has an influx of new veterans." So that we in a sense continue what you call success but in another sense figure out a way to bring others on stream.

That's our problem. That's what we were asking your association to help us delineate, a process whereby we could enable and energize the 16 States that aren't there or have to wait for 6 years to get there to move up in the process.

Mr. **Dack**. Mr. Chairman, we would not have any problem with that. As a matter of fact, we would be happy to work closely with the committee on such a process.

Mr. **Edgar**. Let me ask you another question.

Suppose a State has the money and they would be willing to go ahead at 100-percent renovation or construction of a State veterans home, to bring the home on line within a year, provided that 6 or 7 years from now they would be repaid by the Federal Government when their project finally made it to the top of the list.

Do you think that would make some sense?

Mr. **Dack**. We would not have any problem with that, either. As a matter of fact, I think there are probably some States that do this. However, within the regulations, they don't quite finish the project, so they can demonstrate it's an ongoing project. But if that could be assured within the legislation, I would anticipate no problem with that whatsoever.

Mr. **Edgar**. I failed to ask the question of the VA witness on whether or not that's possible under existing law. I see a shake of the head, which means no.

Mr. **Dack**. It isn't if they complete the total project. It is my understanding it is not, if they complete the total project. But if they leave that project partially finished, then they can come in when their name comes to the top of the list for funding.

Mr. **Bilirakis**. Mr. Chairman, would you yield a moment?

Mr. **Edgar**. Let me yield first to John Paul Hammerschmidt and then I will yield to the gentleman.

Mr. **Hammerschmidt**. Well. I don't know that I have any questions. I appreciate this rather comprehensive testimony. It has a lot of good information.

I did have just a technical question. On the last page of your testimony, appendix 2, page 2, you have a list showing States by rank on veterans population.[1] And then, in addition to that, you have the number of beds.

Is that a bed ceiling?

Mr. **Dack**. Yes, that is the bed ceiling to which the State home program can build with VA participation. We are bound by two-

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[1] See p. 85.

and-a-half beds but can go up to four beds per thousand veterans in a State, meeting certain criteria as established by the Veterans' Administration. There has only been two States in this Union that have bumped up against the upper limit. So many of our States have room in which to grow.

Mr. **Hammerschmidt**. I see. Which States are those, do you recall?

Mr. **Dack**. Rhode Island was bumped up to the ceiling, and I believe Nebraska.

Mr. **Hammerschmidt**. Mr. Dack, we thank you for your testimony.

Mr. **Edgar**. Mr. Bilirakis.

Mr. **Bilirakis**. Mr. Chairman, I sort of thought in your questioning you were leading up to this—and maybe you were, and maybe you're satisfied that you acquired the right answer there.

I guess my question is, is there in place a system, a procedure, which would, in fact, encourage the private sector, the private entrepreneur, to get involved in the nursing home construction business, for all of the right reasons—potential profit and whatnot, as well as, of course, the——

Mr. **Dack**. This program is a State-operated program. The VA has another cost-sharing program, which is the Community Contract Nursing Care Program. So they contract with community facilities. However, with this particular program, no. It has to be a State-operated program.

We can, now, also lease facilities, but we have to be responsible for the operation of that leased facility.

Mr. **Bilirakis**. What I mean is, who initiates the thought of approaching the private sector, to say to them, "Hey, this can be good for business" and at the same time it benefits the veterans? Do we have an initiator of all this, or is it just something that happens, that just takes place? Do we have any sort of a planned scenario, if you will, a selling point, if you will, to the private sector?

Mr. **Dack**. Are you asking about selling the State home program or selling the VA program?

Mr. **Bilirakis**. Well, selling both programs, with the bottom line being to have a State veterans' home, or to have a veterans' home. I don't care whether we call it State, Federal, or whatever the case may be. But to have the veterans' home, that's the bottom line.

Do we have a process in place?

Mr. **Dack**. This is an individual process within each State, and it falls back to the veterans' organizations, the Governors of the State, the people who are interested in providing care for veterans, for the State veterans' home program. We, who already have homes, are strong advocates of working closely with the Veterans' Administration through the MEDIPP process to develop studies for needs for beds, and then we work with our individual States in order to get those beds on line.

Mr. **Hammerschmidt**. Would the gentleman yield?

Mr. **Bilirakis**. Yes, sir.

Mr. **Hammerschmidt**. Mr. Dack, if I recall right, in round figures, private nursing homes take care of about 40 percent of the veterans' needs. State homes take care of about what, 20 percent?

Mr. DACK. Right now, I believe in our situations it's about 25 percent. However, as you know, in the fair market share determined by the VA, that is to be reduced by the year 2000 down to 16 percent.

Mr. HAMMERSCHMIDT. Thank you.

Thank you for yielding.

Mr. BILIRAKIS. Well, all right. I suppose there is not much sense in continuing in that vein. Would it take a veterans' group or maybe an organization of various veterans' groups in a particular area, which would feel there is a need, to initiate some sort of a partnership with private enterprise to do this? Is that basically what we're saying—that there is no process in place whereby the VA or even the State, or the State veterans' organizations would actually do this? There is no process in place in order to be able to sell this to the private sector?

Mr. DACK. The private sector would not qualify to be a State veterans' home under the present law, because it has to be State-operated. It's a Government entity.

Mr. BILIRAKIS. We're talking about the building of a State veterans' home.

Mr. DACK. Well, it has got to be established as a State veterans' home. The application has to be a State-initiated program before funding would be available to build it.

Mr. BILIRAKIS. I guess I'm finished.

Mr. PENNY. Mr. Chairman.

Mr. EDGAR. Mr. Penny.

Mr. PENNY. I just have a couple of quick questions.

Do you know offhand how many State veterans' nursing home beds we have in the State of Oklahoma?

Mr. DACK. Mr. Stewart.

Mr. STEWART. The total of those beds now would be somewhere around 750 spread over five centers.

Mr. PENNY. 750 in those 5 facilities?

Mr. STEWART. Yes, sir.

Mr. PENNY. So we are meeting about half of the quota of beds in the State of Oklahoma right now?

Mr. STEWART. Yes, sir. The State has a proposal now for new home construction, which would be the first new State veterans' home in the State, proposed for Claremore, which is on the waiting list for funding.

Mr. PENNY. You say this would be the first new one for the State?

Mr. STEWART. The first new one.

Mr. PENNY. The five that exist were what, renovations?

Mr. STEWART. Yes, sir. In 1910, Ardmore was built; in 1920, Sulphur was built; in 1972, we converted the Clinton veterans' center from an old TB sanitarium; in 1976, we converted Talihina from an old TB sanitarium; and in 1980, we converted a former facility which belonged to another State agency. By legislation, it became a veterans' center.

We haven't had a new State home constructed in the State of Oklahoma for quite a number of years.

Mr. PENNY. Those conversions of other facilities, in every case but one they were veterans' facilities that were converted?

Mr. **Stewart**. No, sir; they belonged to the State department of health. The TB hospitals in the State were formerly operated by another State agency.

Mr. **Penny**. Did it take special legislation to get those converted under the State grant program?

Mr. **Stewart**. Yes, sir. It had to be converted into—well, first of all, it had to be converted into the department of veterans' affairs. I would mention that those were not converted at Federal expense. They were converted at total State expense without any Federal match in it.

Mr. **Penny**. There was no Federal match for those——

Mr. **Stewart**. No, sir, not at the time they were converted.

Mr. **Penny**. Could there have been, or was the legislation under the State grant program restrictive and would not have allowed it?

Mr. **Stewart**. The State of Oklahoma has spent millions of tax dollars in the last 10 years in upgrading and renovating these veterans' centers to meet life safety codes, and et cetera. For example, at my center at Sulphur, I have been there 19 years. The State of Oklahoma spent $5 million at that center in the last 6 years and not one dime of that has been Federal match.

Mr. **Penny**. At the time they originally converted they did it all at State expense?

Mr. **Stewart**. Yes, sir.

Mr. **Penny**. They didn't make a request for the grant program?

Mr. **Stewart**. Not at that time. It was our feeling in the State, that if the State had the money to do it with—and at that time, with the oil boom days in Oklahoma we did have the moneys and proceeded to do so.

Mr. **Penny**. Would the State have qualified for the Federal grant at that time for conversion purposes?

Mr. **Stewart**. The State would have qualified, yes, sir.

Mr. **Penny**. I'm a bit confused on this point, because it was my understanding that converting homes with Federal grant money was a problem in most instances.

Mr. **Edgar**. It was until we passed some legislation to permit renovations of existing facilities to be included.

Mr. **Penny**. That was my understanding, and that legislation was just approved last year, wasn't it, for conversion?

Mr. **Edgar**. Yes.

Mr. **Penny**. How does that differ from what they have been doing in Oklahoma? How could Oklahoma have qualified, even though they didn't ask for the money, years ago when these were clearly conversions?

Mr. **Stewart**. Prior to 1964 they wouldn't have qualified. Since 1964, in the legislation, the conversion process—I think this is probably where the misunderstanding is.

VA funding is available for renovation processes, and when I talk about converting a State facility, what I'm talking about is taking it from a use from which it was previously built and used and to make the necessary changes in that facility through renovation and equipping and other things to make that satisfactory so far as maintaining geriatric or nursing care patients in.

Mr. **Penny**. Once that conversion was complete, then the additional renovation cost could have been charged to the State grant program if you had requested those moneys?

Mr. **Stewart**. We would have been eligible for a grant through the existing grant program, but chose not to apply for the grants because, as I said, the State of Oklahoma in those days had the money from oil and et cetera.

Mr. **Penny**. I got you.

Thank you, Mr. Chairman.

Mr. **Edgar**. Can you tell me why Texas has no State veterans homes?

Mr. **Dack**. Mr. Chairman, we have wondered that ourselves. I believe the association has worked closely with Texas in attempting to develop a State home. But the interest is not there. If the interest is not in a State home, it is most difficult to get people interested.

Mr. **Edgar**. Can you tell me why Florida is still on the waiting list?

Mr. **Dack**. Florida is on the waiting list because of the fact that it has just been recently that they have decided to build a State home. As I alluded to in my testimony, we worked with them back in the early seventies about developing a home. Now it has just come to the point where they have decided they want one and are working toward it. Based upon first come/first served, they are in line for funding.

Mr. **Edgar**. When?

Mr. **Dack**. It depends on the appropriation. If the Congress appropriates the funds——

Mr. **Edgar**. Your best guess.

Mr. **Dack**. Let me see when they're on the list.

I would imagine either 1987 or 1988.

Mr. **Edgar**. Thank you.

Are there any other questions? Thank you for your testimony. I appreciate your coming today.

Mr. **Dack**. Thank you.

Mr. **Edgar**. I wonder if Dr. Mather would come back to the witness table just to answer one question. Would you be willing to do that, Dr. Mather?

Dr. **Mather**. Yes, Mr. Chairman.

Mr. **Edgar**. I appreciate your coming back.

Let me ask you the question that I asked earlier: If a State decided today to go ahead and construct or renovate a home that they would like to participate in the State veterans home program—they make application and they see that they have to be on that list for 6 or 7 years—and they decide to use State resources today to complete that renovation or that construction, what is the legal prohibition for you, as the VA, not to at some point in the future reimburse that State for their construction or renovation costs?

Dr. **Mather**. We have understood, and the general counsel has so ruled several years ago, that under our current statute, if a State initiates the renovation, building, purchase of a home and takes the whole project to closure, then we are precluded from reimbursing that State, per se, for the expenditure of those funds up to the 65 percent level as provided by law.

Now, I know that the general counsel is revisiting that issue at this point in time, but I have not seen any indication that they're going to change their original ruling.

Mr. **Edgar**. Would you have any problem, after that report is given, if there is a suggestion for a change in law, would you have any problem with setting a program together, where States who are at the bottom of the list, if they wanted to go ahead and initiate the action, what would be the limitations that you would have?

Dr. **Mather**. If you change the program in that way, Mr. Chairman, I think the only assurance that we would have to have is that they have, in fact, done the job according to Hoyle, as it were, that they have, in fact, fulfilled all the Federal specifications and so forth, and that there are no "leaky faucets," to use another phrase.

I think that we would be in a good position to provide assistance out of our office and from the Office of Construction, as we constantly do at this point in time with all projects that come in, to assure the States that they, in fact, would be able to be in compliance. I think, though, I would have to say that the way in which we keep a "hands on" role in stroking those projects through does, in fact, ensure that the States do things in an appropriate way. So there is an element of risk here still for the States.

Mr. **Edgar**. Finally, wouldn't there be a problem—even though I'm arguing against my own proposal here for a second—wouldn't there be a problem—let's say all the States went ahead and did that, we change the law and let them go ahead and set up their State homes. The day after they were opened, there would be some commitment to the per diem costs, that is, the day-to-day costs.

Wouldn't there have to be a budget item some place in the Federal budget to account for that increased number of nursing home beds or domiciliary home patients, that we would be responsible for 25 or 30 percent of their care?

Dr. **Mather**. There is no question about it, Mr. Chairman. Over the past couple of years we have run into some circumstances where the States have determined to convert their domiciliary beds to nursing home beds, which as you know as a per diem rate is much higher. We have had to essentially institute measures over the past couple of years that will give us a much better notification of when those conversations are going to take place, because we have to build a budget, for instance, as it were, for fiscal year 1987 starting right now. We have to know those kinds of figures to calculate the per diem rates.

I think also there's another thing I would like to point out about the construction program. It seems to me that if it were known that the States had already completed a project and expended all the money, there might be an argument made for why should the Federal Government reimburse them. They've done the job, they have made the commitment, and therefore they have done their job.

Mr. **Edgar**. Thank you.

Are there any other questions of this witness? Thank you very much.

Dr. **Mather**. Thank you, Mr. Chairman.

Mr. **Edgar**. I would like to recognize that in the audience today is John Vogel, who is the former Director of the VA Regional

Office in Philadelphia. He is now the newly appointed Chief Benefits Director of the VA.

John, do you want to stand so everybody can see you? Welcome. [Applause.]

Mr. **Edgar**. If there are no other statements or questions, I would like to recess for 2 minutes, to begin the markup in that 2 minutes. We need to just get our heads together on the markup.

[Whereupon, at 10:20 a.m., the subcommittee proceeded to other business.]

APPENDIX

Prepared Statement of Hon. Bill Nichols, a Representative in Congress From the State of Alabama

As Congressman of the 3rd District of the Great State of Alabama, I am honored today to give testimony on this proposed legislation.

In my opinion, the Veterans Administration should be highly commended for creating the State Home Construction Grant Program in 1964.

The State Home Program is a highly cost-effective alternative to VA and Community Nursing Home Care.

The Veterans Administration has predicted that veterans will comprise the major portion of the male, aged population for the remainder of this century. Currently, one (1) out of three (3) males in the U.S. over age 65 is a veteran. By the year 2000, this figure wil increase to approximately two (2) out of every three (3) males. The number of veterans requiring long-term nursing home care is expected to increase to over 300,000 by the year 2000.

The Veterans Administration has estimated that the demand for nursing home beds would increase by about 50,000 beds between 1980 and 1990, and by another 100,000 by the year 2000.

According to the Veterans Administration Medical District 10 study in 1979 (which includes the entire State of Alabama, the southern half of Mississippi and the Florida panhandle), some 60% of the veterans in this District have received care in VA-related nursing homes. District 10 ranks number 3 in the country, out of the VA's 28 medical districts in reference to veterans receiving VA related nursing home care.

In addition the Veterans Administration's 1984 MEDIPP report estimates that Alabama currently has over 60,000 veterans of the World War II era and this figure wil more than double to 130,000 by the year 1990.

Alabama currently is some 1,200 nursing home beds deficient for veterans needing long-term VA nursing home care.

Presently the Veterans Administration operates only 232 nursing home beds in the State of Alabama. In addition, Alabama's 220 private sector nursing homes are currently operating at over 97 percent occupancy.

These tragic numbers certainly indicate the critical need for a State Veterans Nursing Home in Alabama.

This critical need situation is why I appear before you today. Under current Veterans Administration policy, the State Home Grant Program is administered on a first-come, first-served basis with no consideration given to states like Alabama who currently do not have any State Veterans Nursing Homes—while the demand for such services is skyrocketing.

Alabama, as I understand, currently ranks number fifty (50) on the Veterans Administration State Home Grant Program. We have been told that the 65 percent funding by the VA could be anticipated by the year 1990.

The needy and deserving aged veterans of Alabama are in critical need of this home now, not in five or ten years.

The Governor of our great State, the Honorable George C. Wallace, a combt veteran of World War II; recognizes the severe need of this State Veterans Home and has committed the state's 35 percent funding for this project by October 1986. I am deeply proud and appreciative of Governor Wallace in supporting this worthy endeavor.

For your information, the site for Alabama's first Veterans Home, as chosen by the State Department of Veterans Affairs, is Alexander City in Tallapoosa County, which happens to be in my Congressional District.

I totally endorse the Veterans Administrations State Home Construction Grant Program in providing cost-effective, long-term nursing home care to needy veterans.

However, I feel the current funding policy should be altered from the strictly first-come, first-served basis, in that no consideration being given to any need factors.

The proposed factors in your bill relating to a determination of need are most worthy.

May I offer other possible points for consideration of need justification as determined by the VA. Should the VA not give some priority to States that have applied for state home funding that do not have any such existing homes when justifiable need is substantiated?

In addition, to fully justify and recognize states with high-priorty need situations, the Veterans Administration might want to rely on data and information provided by its current long-term planning system—better known as MEDIPP—which stands for Medical District Initiated Program Planning.

For the committee's information, in October 1981 the Comptroller General of the United States made a State Veterans Home report to the Honorable Alan Cranston.

One of the major objectives of this report was to determine whether the VA effectively plannned and coordinated the construction and/or use of VA, State, and community nursing homes to meet the estimated needs for nursing home beds. The Comptroller General's Report of 1972 suggested that the VA Administrator determine the need for State home facilities before approving grants prior to their construction. However, the VA has continued to approve grants without determining whether the project is needed.

The report further suggested that each proposal for construction under the State Home Program be supported by meaningful data regarding the need for the facility and that the VA fully evaluate such data before approving any grant.

In this same report, the Comptroller General questioned the VA's position of having no legal authority to assess the need for State home beds. It stipulated that VA is required to establish, by regulation, the "number of beds required to provide adequate nursing home care to veterans residing in each State." (Title 38 U.S.C. 5034[1]). And Title 38 U.S.C. 5035[b] states that the Administrator shall approve any grant if, among other things, "the construction of such project, together with other projects under construction and other facilities, will not result in more than the number of beds prescribed by the Administrator pursuant to section 5034[1] of this title for the State in which such project is located being available for furnishing nursing home care to veterans in such State."

I fully concur with the results of the Comptroller General's Report and support your proposed legislation.

I feel there is a significant precedent involved here as to the current VA policy regarding approval of State Home grants being in conflict with Title 38 U.S.C. 5034(1).

It is my opinion that the VA Administrator should immediately amend current VA regulations as to establish comprehensive and justifiable criteria relating to the intent of the law as passed by Congress.

Mr. Chairman, thank you very much for allowing me to appear before your subcommittee this morning.

STATEMENT OF
DR. JOHN GRONVALL
DEPUTY CHIEF MEDICAL DIRECTOR
VETERANS ADMINISTRATION
BEFORE THE SUBCOMMITTEE
ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES
May 2, 1985

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here this morning to offer our views on legislation pending before the Subcommittee.

Mr. Chairman, I will begin by commenting on H.R. 788 which we favor subject to certain technical amendments. Our ability to hire and retain graduate nurses and student nurses is currently limited by two circumstances, and H.R. 788 addresses both.

Recruitment and Retention of VA Graduate Nurse Appointees

We appoint graduate nurses temporarily for one year during the period between graduation from nursing school and the time when they become formally registered by a state board of nursing. We naturally expect that the graduate nurses we appoint will become registered, and the power to attract graduate nurses immediately after graduation gives us a helpful source for nurses who eventually become tenured full time VA nurses. But the attractiveness of VA to graduate nurses is now limited by the Government-wide bar against Government-sponsored health and life insurance for persons whose appointments last only one year. (This bar is at 5 C.F.R. §§ 870.202(a)(1) and 890.102(c)(1)(1984).) Having had the insurance as a nursing student, the newly appointed graduate nurse must now get his or her own insurance or find pre-registration employment outside the Government. We lose many potentially fine career nurses because they prefer an employer who can offer insurance benefits to them as graduate nurse appointees.

H.R. 788 would solve this problem. Paragraph(a)(1) of the bill would amend the appointment statute, section 4114(a)(3)(A), by allowing graduate nurse appointments to exceed one year.

We naturally support enlarging the appointment authority, but our experience shows that no more than two years is needed to allow the nurse registration process to conclude. Therefore, we suggest that the bill be changed simply to raise the maximum appointment from one to two years.

Recruitment and Retention of VA Student Nurse Appointees

We appoint student nurses under the same statute, and the appointing authority for student nurses has been no less valuable a way of identifying promising candidates for VA nursing careers. But current law has precluded hiring them for more than one year; so many leave before graduating. In many cases, those who leave find employment and develop careers outside VA. By changing the statute to authorize reappointment of student nurses, paragraph (a)(2) of the bill would make sure VA can retain those student nurses we find promising, at least until they graduate from nursing school.

We also suggest deleting the word "technician" from any amendment as it does not appear in the current statute.

If enacted, this provision would not result in a significant cost to the VA.

I shall next comment on H.R. 789 which would accomplish several of the purposes of a draft bill which we submitted to the Speaker of the House on March 27, 1985. Our draft bill also would extend two other expiring health care authorities: VA's authority to provide contract hospital care, and outpatient care that will obviate the need for hospital admission, to certain veterans in Puerto Rico and the Virgin Islands and the President's authority to contract with the Veterans Memorial Medical Center (VMMC) in the Philippines to provide payment for hospital and nursing home care to United States veterans in that facility. We urge that the Subcommittee also take action to extend these authorities.

Extension of the VA Treatment and Rehabilitation Program for Alcohol and Drug Dependence and Abuse Disabilities

Section 2 of H.R. 789 would extend for an additional three years, through September 30, 1988, VA's authority to conduct its pilot program to contract for care, treatment, and rehabilitation services in halfway houses, therapeutic communities, psychiatric residential treatment centers, and other community-based treatment facilities for eligible veterans suffering from alcohol or drug dependence or abuse disabilities. This authority is due to expire on September 30, 1985. This provision would also require VA to submit a report to the Senate and House Committees on Veterans' Affairs by December 31, 1987, on the operation of this program.

We strongly favor extending for an additional three years VA's authority to contract for treatment and rehabilitation of veterans suffering from alcohol and drug dependence in community facilities such as halfway houses. A study mandated by Congress indicated that this contract authority has been and would continue to be a cost-effective method to supplement VA treatment and rehabilitation of certain veterans. As of the end of Fiscal Year 1984, 83 VA medical centers had contracts with 297 non-VA community-based programs, and 16,685 veterans had been placed for treatment in these contract facilities. The program evaluation study revealed strongly encouraging follow-up measures of maintained sobriety, active roles in Alcoholics Anonymous, and increased employment and monthly income. There are sufficient data on the treatment benefits and cost-effectiveness of contracting for treatment and rehabilitation of these relapse-prone veterans to warrant continued authorization for such care. We estimate the cost of extending the pilot alcohol and drug treatment program to be $6.1 million for Fiscal Year 1986 and each of the following two fiscal years. The 1986 budget includes funding for the continuation of this program.

Extension of the VA State Home Construction Grant Program

Section 3 of H.R. 789 would extend through Fiscal Year 1989 VA's authority to provide grants to States for the acquisition, construction, remodeling, or renovation of State home facilities for furnishing hospital, domiciliary, and nursing home care to eligible veterans. This authority will expire at the end of Fiscal Year 1986.

VA favors section 3 of this bill. However, we request that this authority be extended for five more years--through Fiscal Year 1991--instead of the three-year extension proposed by H.R. 789.

This cost-effective grant program makes it possible to extend medical care to veterans beyond that which is provided in VA facilities by assisting States in the construction, acquisition, remodeling, and renovation of State home facilities. There are now State homes in 33 States. Nursing home care is provided in 42 homes, domiciliary care in 41 homes, and hospital care in 7 homes. From Fiscal Year 1966 through Fiscal Year 1984, approximately $150 million was obligated in support of new nursing home care and domiciliary beds and for remodeling and modifying existing buildings. Seventy-nine percent of the funds have been used for bed-producing projects. The remainder has been used for remodeling and renovation. The estimated cost of grants to State homes is $22 million for Fiscal Year 1987 and each of the next two fiscal years. The outyear estimates in the 1986 budget include funding for the continuation of this program.

Elimination of the One-Third Limitation on State Home Construction Grants

Finally, section 4 of H.R. 789 would eliminate the limitation in 38 U.S.C. § 5035(d)(2) which provides that no one State may receive in any fiscal year more than one-third of the amount appropriated in that fiscal year for grants to assist States in the acquisition or construction of State veterans' homes.

We favor enactment of this section of the bill. This limitation was enacted to prevent perceived abuses in the grant program. It was believed that a few States had received inequitably large grants. This limitation has not, however, prevented the approval of any State home grant request. Because Congress typically permits funds appropriated for State home construction grants to remain available for three fiscal years, a large grant can be funded from more than one fiscal year's appropriation. As a result, the only effect of this limitation is to delay approval of large State home grant applications until enough money to fund the grant can be accumulated from different fiscal years' appropriations. Enactment of this provision should not result in any additional costs.

8.

Revision of State Home Construction Grant Program

Mr. Chairman, you advised in your letter of April 18, that the Subcommittee also seeks our views on a draft bill aimed at revising the operation of the State home construction grant program. Under existing law, the VA must approve a grant application if the VA determines that it meets the requirements of 38 U.S.C. § 5035. The statute leaves the VA with little room to rank grant applications according to priorities or relative need. As a result, the VA approves grants as funds become available in the order in which grant requests are received. The draft bill would change this procedure so as to provide for granting awards based on need as determined by VA. The bill would require the VA to determine the need for each State-proposed project in relation to all other grant applications received by the VA. In determining the relative need for a project, the VA would be required to consider three factors specified in the bill as well as such other matters as the VA considers appropriate. The three factors to be considered are: 1) the projected number of veterans who may apply for admission to the facility over the facility's useful life, 2) the presence of VA facilities in the geographic area of the proposed project that may be available to provide nursing home or domiciliary care to veterans, and 3) the number of other facilities in the geographic area of the proposed facility that may be available to provide nursing home or domiciliary care to veterans. After a determination of the relative need for a project, the Administrator may approve the amount of assistance applied for in whole or in part. An application could not be approved, however, unless the project met the VA's construction, repair, and equipment standards and did not exceed the maximum number of nursing home beds for veterans in that state set by VA regulations.

In addition, the draft would require the VA to submit each year to the Committees on Veterans Affairs of the Senate and House of Representatives a list of states which have submitted applications that meet the statutory requirements and the VA's recommendations as to the relative priority of each application on the list. The draft also directs that an appropriation may not be made for State home grants unless the Veterans Affairs Committees of the Senate and House of Representatives first adopt a resolution approving each proposed grant.

Finally, the draft would provide for a transition period to permit approval under existing procedures of preapplications submitted to the VA prior to October 1, 1985. The bill provides that if the states which submitted these preapplications file a complete grant application by October 1, 1987, the VA shall approve the grant in accordance with the procedures in effect prior to October 1, 1985.

This proposal would constitute a substantial revision of a longstanding program. As we understand it, this bill is intended to assure that State home construction grants are awarded on the basis of relative need as determined by the VA. There appear to be two major premises underlying this proposal. The first is that the existing program fails to address VA's need for State initiated projects. The second premise is that Congress must totally transform this smooth-running grant program in order to assure that grants are targeted to most-needed projects. We disagree with both of these premises. We thus suggest that an alternative approach be considered.

It should be stressed that VA's needs for individual State home projects are very much an element of the overall design and operation of this and related programs. Although the State home program does not itself involve prioritization determinations, VA's systemwide construction planning process (MEDIPP) takes direct account of State home capacity and proposed State home construction. In effect, therefore, VA planning does involve a prioritization of needs in any given state. For instance, in a state like Florida which has no State home, VA construction plans have been given high priority because of the level of need. In other states which have a lesser need in part because of the existence of State homes, VA construction plans receive a lower priority. In addition, states simply do not apply for grants for projects that are not needed. Although the VA funds up to 65% of the construction cost, the state must fund the rest, and is also responsible for operating the facility after it is built.

Finally, we note that relative need for a project is already provided for to the extent that the law proscribes VA from approving a grant if construction of the project will result in more than 4 nursing home beds per 1,000 veterans in that state. Moreover, a state requesting a grant for a project which would result in more than 2-1/2 nursing home beds per 1,000 veterans in a state must provide sufficient justification for the VA to determine that the additional beds are required.

The stated purpose of this proposal is "to provide for participation by more States in the program of grants to States for construction of State veterans' homes." In our judgement, however, the enactment of this proposal could be counter productive in that it could discourage many states from applying for State home construction grants. Currently, if a state undertakes the expense of submitting a complete formal application (which could cost up to 10% of the project's cost), the law requires VA approval of the application as long as it meets the requirements of section 5035. The draft bill would eliminate this assurance. Instead, the draft bill gives VA discretion to decide to approve, delay, or disapprove a grant. In addition, the bill permits the VA to approve a funding request in whole or in part. Thus, a state which embarks on the costly process of applying for a VA construction grant would have no assurance of obtaining funding assistance in advance of obligating funds to obtain needed architectural plans and specifications, for example. Even if a State believed it could obtain VA approval, it would face uncertainty as to whether Congress would appropriate funds for its project in view of the provision of the bill that funds may not be appropriated unless the Senate and House Veterans' Affairs Committees have first adopted a resolution approving each grant. Because of this uncertainty, we anticipate that States would be less likely to plan and request funding for State home projects if this bill is enacted.

We recognize that there may be criticism that the existing law and Agency programs do not give sufficient weight to relative need among State home projects. We strongly recommend that the subcommittee give most careful consideration to "fine-tuning" the existing program design rather than discarding it altogether. Thus, we recommend that further study be given to such options as adjusting the funding formula, for example, to authorize the VA to determine the percentage of the construction cost for which VA will approve a grant. Alternatively, a maximum number of nursing home and domiciliary beds based on the veteran population and the availability of other beds for veterans in each state could be set by law. The law would then prohibit grants for projects which would create more than this number of beds in the particular state. The law currently permits VA to establish the maximum number of nursing home beds for each state. The VA has done so on the basis of veteran population in each state.

If enacted, the draft bill would increase the administrative cost of the State home program. Our estimate for this cost is approximately $240,000 for each of the next five fiscal years.

H.R. 1303-Transfer of Functions to a New Prosthetics Assessment and Information Center

We favor the enactment of H.R. 1303 which would waive the required waiting period for certain VA reorganizations to permit the transfer of certain functions from the VA Prosthetics Center (VAPC) in New York City to a new Prosthetics Assessment and Information Center (PAIC) in the Washington, D.C. area. Enactment of this measure would accomplish the purposes of a draft bill which we submitted to Congress on February 1, 1985.

Under the Congressional "report and wait" requirements of 38 U.S.C. § 210(b)(2), a detailed plan and justification must be submitted to the appropriate committees of Congress prior to the implementation of certain administrative reorganizations involving a reduction during any fiscal year by ten percent or more in the number of full-time equivalent employees (FTEE) at a VA covered office or facility. The report must be made not later than the date on which the President submits his budget for the upcoming fiscal year. Thereafter, no action can be taken to implement the reorganization until the first day of that fiscal year. Although the VAPC reorganization was reported to Congress on February 1, 1985, it cannot be implemented prior to fiscal year 1986 under the "report and wait" restrictions of 38 U.S.C. § 210(b)(2). In order to begin implementation of the VAPC reorganization as soon as possible and thereby realize the expected improvement in the provision of the VAPC functions much sooner, the Agency also proposed enactment of a legislative waiver of the waiting period.

Currently, administration of the major elements of the prosthetics program is divided between two Assistant Chief Medical directors in Central Office, the ACMD for Professional Services, and the ACMD for Research and Development. The overall reorganization will consolidate administration of all prosthetics activities, including rehabilitation research, in Professional Services, under the direct control of a new Deputy Assistant Chief Medical Director for Prosthetics Services, Research and Development. This will improve the provision of prosthetics service by providing an appropriate focus, centralized guidance, and improved coordination of prosthetics activities.

The planned, new PAIC, located in the Washington, D.C. area, will be responsible for managing and coordinating all prosthetics administration, testing, evaluation, and information dissemination. This Center will: test and evaluate new commercially available devices and procedures; prepare and disseminate informational material and program guides regarding testing prosthetics and sensory aids; and provide technical information and assistance. As indicated above, the missions of the PAIC will replace those of the Technology and Performance Evaluation Section and the Information and Education Service, both now located at the VAPC in New York. Locating the PAIC in the Washington, D.C. area will facilitate direct control and coordination of PAIC's mission from VA Central Office. The positions to staff the PAIC will come from 24 FTEE positions now allocated to the VAPC for these functions.

H.R. 1818-Release of a Limitation on the Use of Real Property in McKinney, Texas

H.R. 1818 would remove the restriction on two parcels of land deeded in 1965 by the VA to the City of McKinney, Texas. The restriction, which was imposed in accordance with Public Law 88-438, requires that the two parcels of land, totalling 38.741 acres, be used for park and recreational purposes. The City has now requested the removal of these restrictions so it may sell the property. The City proposes to use the proceeds to purchase land better suited for recreational activities. Because the VA no longer has a facility in McKinney, Texas, we have no objection to removing this restriction.

Chiropractic Care Demonstration Project

Mr. Chairman, you have also asked us to discuss a draft bill which would require the Veterans' Administration to conduct three geographically dispersed demonstration projects for the purpose of evaluating the cost effectiveness of providing chiropractic care to veterans. We strongly oppose enactment of this bill.

As you know, the Congress has mandated that the primary function of the Department of Medicine and Surgery is "to provide a complete medical and hospital service . . . for the medical care and treatment of veterans." This longstanding mission statement is set forth in section 4101 of title 38, United States Code. We believe it is important to recognize that, under law, the VA health care system has long been based on the medical model. As architects and builders of that system, this Committee has certainly been instrumental in assuring that our hospitals are providers of quality medical care.

Surely the concept of conducting a demonstration project, as proposed in the draft bill, is premised on the notion that one would intend to establish a permanent program based on the "success" of the demonstration. As we testified before this Committee on June 28, 1983, we strongly recommend against establishing such a program. In reiterating that point we would underscore that establishing a VA role as a provider of, or payor for chiropractic services would represent a fundamental change in the function, focus, and orientation, and potentially in the structure, of that health care system.

In essence, we can see no need for providing chiropractic service, nor for studying it further. The therapeutic capabilities of the existing VA medical staffs and consultants are comprehensive and flexible, and fully meet the needs of all veteran patients. We strongly believe that disorders of the musculoskeletal system are skillfully and appropriately treated in the VA by physicians, medical and surgical subspecialists, and specialized support personnel. We simply do not see a role for chiropractic in the VA system.

It is not our intention to rekindle debate and attempt to persuade you at this time to reject the scientific or therapeutic validity of chiropractic. Our efforts to study the available literature, however, have revealed little evidence that chiropractic schools or the chiropractic industry at large has conducted significant scientific research regarding the efficacy of chiropractic. We question then why the VA should be asked to undertake a study of the cost effectiveness of chiropractic services as proposed in this bill. Such a requirement, in any case, would be extremely difficult to accomplish. We would envision the need to design a study that would compare chiropractic with other forms of therapy. From a purely scientific point of view, this would be a very complex undertaking. Establishing the health problems to be studied and recruiting sufficient numbers of patients to obtain statistically significant data will both prove very difficult. Equally troublesome will be establishing the effectiveness of treatments. For example, there are simply very few objective measures for determining improvement of low back pain, one of the most common musculoskeletal problems. If meaningful scientific results are to be achieved, we would anticipate that such a study would be likely to cost at least $7 million and might well require considerably more time than the three years proposed.

Finally, Mr. Chairman, let me highlight the fact that VA has the challenge of meeting its existing mission in the face of fiscal constraints. Accordingly, we must object to the imposition of new requirements that would oblige VA to divert resources from ongoing programs to efforts of such questionable value.

In essence, we urge the Subcommittee to reject this bill.

Mr. Chairman, that concludes my statement. I would be pleased to respond to any questions you or any other member of the Subcommittee may have.

VETERANS OF FOREIGN WARS OF THE UNITED STATES

OFFICE OF THE DIRECTOR

STATEMENT OF

DENNIS M. CULLINAN, SPECIAL ASSISTANT
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

FOUR BILLS AFFECTING VA MEDICAL CARE

WASHINGTON, D.C. MAY 2, 1985

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the Veterans of Foreign Wars of the United States, I would now thank you for the privilege of appearing before this distinguished Subcommittee so that we may present our views with respect to H.R. 788, H.R. 789, H.R. 1303, and H.R. 1818. We would further express our appreciation of the Chairman for holding this hearing, evidencing his and this Subcommittees concern that this nation's veterans continue to receive the highest level of health care through the workings of the Veterans Administration Medical System.

The enactment into law of H.R. 788, introduced by the Chairman of this Subcommittes, would allow for the appointment by the Veterans Administration of temporary full-time nurses who will be pursuing graduate nursing degrees to exceed one year. It is our opinion that this would enhance the Department of Medicine and Surgery's ability to both recruit and retain the requisite highly skilled nursing personnel needed to provide first-rate health care to veterans. The Veterans of Foreign Wars, therefore, supports the passage of this bill.

Also of consideration at this time is H.R. 789, the Veterans' Health Programs Extension Act of 1985, introduced by Chairman Edgar for himself and Messrs. Mica and Lehman, would, among other purposes, extend the Administrator's authority to contract for care, treatment and rehabilitative services for veterans suffering from alcohol or drug related disabilities until September 30, 1988. The VFW is, in the main, supportive of enactment provided that certain concerns are met.

We hold that such care should only be provided on a contractural basis in areas where suitable VA facilities are not readily available. Further, the veteran should remain on an "active" patient status so that all medical needs may be met by the VA without his having to reenter the system. In our opinion, it should be the VA's responsibility to ensure that veterans are afforded the highest level of care by such contracted facilities and services. Finally, it is our concern that this means of providing medical care be cost-effective in both the short and long term. It is of tantamount importance that the provision of medical care on a contractural basis not in anyway compromise the VA's own ability to properly and compassionately provide for the health needs of this nation's deserving veterans.

The next bill for consideration, H.R. 1303, introduced by Chairman Edgar, would permit the transfer of functions of the Technology and Performance Evaluation Section and the Information and Education Service at the Veterans' Administration Prosthetics Center in New York, New York, to a new Prosthetics Assessment and Information Center in the vicinity of Washington, D.C., without regard to the Congressional notice-and-wait requirements of 38 USC 210.

The purpose of this measure is to facilitate reorganization within the VA Department of Medicine and Surgery to create a Prosthetics Assessment and Information Center (PAIC) which would be under the direct control of a single manager, the Deputy Assistant Chief Medical Director for Prosthetics Services, Research and Development. The Center is to be located in the Washington, D.C. area. This is being undertaken in order to facilitate the delivery of high quality care and at the same time provide a central locus for development of new and better prosthetic devices and services. Inasmuch as we believe this would greatly enhance the quality of medical care afforded disabled veterans, the VFW strongly supports the expeditious enactment into law of H.R. 1303.

The final bill to be considered at this hearing, H.R. 1818, introduced by Congressman Armey, would release the limitation to recreational purposes only on property conveyed by the Administrator of Veterans' Affairs to the city of McKinney, Texas on May 5, 1965. It is our understanding that this action would have no detrimental consequences for either the VA or veterans and we would, therefore, have no objections to the passage of this bill.

Mr. Chairman, I would once again express our appreciation of yourself and this Subcommittee for having requested the participation of the Veterans of Foreign Wars in this most worthwhile hearing. This concludes my testimony, and I will be happy to answer any questions you may have.

PVA
PARALYZED VETERANS
OF AMERICA
Chartered by the Congress
of the United States

STATEMENT

FOR THE RECORD

OF

FRANK R. DEGEORGE, ASSOCIATE LEGISLATIVE DIRECTOR

PARALYZED VETERANS OF AMERICA

BEFORE THE

SUBCOMMITTEE ON HOSPITALS & HEALTH CARE

OF THE

HOUSE COMMITTEE ON VETERANS' AFFAIRS

CONCERNING

H.R. 1303, Transfer of VA Prosthetics Center

May 2, 1985

Mr. Chairman and Members of the Committee, it is a pleasure for Paralyzed Veterans of America to present the views and concerns of its members on the legislative proposals being addressed. Although the proposals cover a wide range of health-care issues, we will only express our opinion on H.R. 1303.

Specifically, PVA is supportive and in favor of H.R. 1303, introduced by Chairman Robert Edgar. The legislative proposal provides that the Administrator of Veterans' Affairs proceed with the transfer of certain functions within the Department of Medicine and Surgery of the Veterans

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Administration without regard to the Congressional notice and wait requirements of Section 210 of Title 38, United States Code.

PROSTHETICS RESEARCH PROGRAM

PVA's involvement in the area of the Veterans Administration's prosthetics programs encompasses research, development, evaluation, acquisition, and distribution of the working product, and the performance of repairs on those items. It is appropriate to illustrate how important the subject of prosthetics is to all of PVA's members and to those other veterans and nonveterans whom we represent (or with whom we interact through our National Service, Advocacy and Research Programs).

A person who has incurred spinal cord injury or dysfunction is generally dependent upon varying types of prosthetic devices from the time of initial medical treatment through the remainder of his or her life. This is most evident during the rehabilitation stage when prosthetic devices are utilized to help adapt and train the SCI individual to his or her new lifestyle. Then, when the individual returns to life outside the hospital, a wide range of additional prosthetic devices are needed to assist him or her in performing activities of daily living.

Prosthetics aids for the SCI veteran cover a wide spectrum of available devices and, it is, safe to state, that each individual's need for prosthetic aids are as unique as the person's disability. These devices can be as simple as a molded wrist-finger adapter designed to hold a fork or spoon to assist in self-feeding, or as complicated as an integrated mechanical and electrical system which would permit a quadriplegic with little strength to operate a specially modified van. In addition, experimental prosthetics such as breath-activated environmental controls and functional electrical stimulation (FES) devices are presently in development, and offer an ever growing promise of increased independence for severly disabled persons.

It should be noted that current FES research is just beginning to come of age. A wide range of projects have analyzed and demonstrated the vast potential for FES applications. Now, this research is approaching its second generation where various aspects will be combined which will produce more refined processes and improved applications that hold even greater promise.

Currently, PVA's members use a wide range of prosthetic devices and/or aids such as leg braces, Canadian crutches, and manual, powered and sport wheelchairs which enable them to lead fuller, more productive lives. The advent of FES applications will expand greatly the role of many existing devices as well as open a broad range of as yet undetermined aides.

An example of the real potential of VA prosthetic research is the new "Seattle Foot" developed by Dr. Ernest Burgess of the Seattle VAMC. This prosthetic device represents a second generation of an appliance which has dramatically improve the lives of amputee veterans. The "Seattle Foot" prosthesis was demonstrated at the Subcommittee on Hospitals and Health Care hearings last spring. And, recently Dr. Burgess was presented with a "Presidential Award of Excellence" for his work in developing this new and safer prosthetic device. Such stories may soon be repeated for FES if the research environment of the VA is maintained at a level which promotes ever increasing research.

The VA and the United States, once the acknowledged leaders in prosthetic research and application, has, due to a multiplicity of factors, particularly decreased funding, lost this leadership role. Clearly, the budgeting policies of the early 1980's showed that prosthetic research was not a high priority item for the federal government. The policies of the Carter and the early Reagan Administrations reduced prosthetic research funding and staffing levels.

Fortunately, this trend began a positive reversal in Fiscal Year 1983. The Fiscal Year 1984 program experienced an 11 percent increase in staffing and budget authority. The Fiscal Year 1985 budget added another 25 employee positions, bringing that total to 263, and increased the budget authority to $15.264 million, which translated into a 45 percent increase. PVA views these increases as extremely positive changes for prosthetic research. We are pleased that the Fiscal Year 1986 budget proposes to maintain this trend, though not as vigorously as in Fiscal Year 1985.

Since many VA developed prosthetic devices are marketed by "for-profit" companies, PVA recommends the VA prosthetic research program develop a proposal to create a revolving fund which could be designed as a technology transfer mechanism. This special fund could be employed by the VA to offset the cost of bringing certain devices from a research agenda to the marketplace. Such a fund would provide an encouraging signal for researchers and design engineers to concentrate on the development of improved prosthetics, utilizing the very latest technologies available.

PVA believes that a VA "Prosthetics Research Revolving Fund" is an idea worthy of consideration. This special fund, with monies generated either by royalties received from the commercialization of prosthetic research products or from the sale of a given prosthetic patent, could, perhaps, make the VA prosthetics research program self-supporting. Legislative consideration may be needed before such a fund could be created, since the legal aspects would need to be thoroughly explored, but the advantages to the VA and to disabled veterans alike could be enormous.

Mr. Chairmen, PVA would be remiss if we did not take the time to compliment you and the VA for their efforts to consolidate the prosthestic research program. In the past we have been rather critical of the VA for their fragmentation in this critical area of research, but our concerns should be well addressed by the collocation plan currently being considered.

Under the proposed reorganization certain functions of the VA Prosthetics Center (VAPC), which is currently situated in New York City, would be transferred to the new Prosthetic Assessment and Information Center (PAIC) here in Washington, D.C. The planned, new, PAIC will be responsible for managing and coordinating _all_ prosthetic administration, including testing, evaluation, and information dissemination. The Center will test not only newly designed VA prosthetics but also new commercially available devices and procedures; and with it being located in Washington, D.C., should greatly improve the overall coordination which has been needed by VA Central Office personnel. This proposal offers the VA great opportunity to regain its world leadership in the area of prosthetic research and product development.

PVA would also like to go on record as supporting the Administrator's request for a legislative waiver of the "report and wait" restrictions imposed by 38 U.S.C. Section 210(b)(2). The granting of this waiver, which we understand is presently continued in H.R. 1303, will enable this new Center to take shape and begin operation this Fiscal Year rather than next.

The VA and the United States, once the acknowledged leaders in prosthetic research and application, has, due to a multiplicity of factors, particularly decreased funding, lost this leadership role. Clearly, the budgeting policies of the early 1980's showed that prosthetic research was not a high priority item for the federal government. The policies of the Carter and the early Reagan Administrations reduced prosthetic research funding and staffing levels.

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In conclusion, we are certain that the Members of the Subcommittee, both individually and collectively, share ,views similar to those of PVA. Our mutual goal is to make the programs, which you have created, work efficiently and to their fullest potential. National priorities are reflected through the federal authorization-appropriation process; therefore, we stress to you that the greatest expression of concern which the Committees can display for veterans is to persuade others in Congress to preserve existing veterans' programs and to make those programs serve the persons for whom they are intended.

We know you have done this in the past, we feel confident you will continue to do so in the future, and we thank each of you for serving in the Congress and for being on these Veterans' Affairs Committees. I appreciate this opportunity to provide testimony on behalf of the members of PVA.

STATEMENT OF
DAVID W. GORMAN
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
FOR MEDICAL AFFAIRS
DISABLED AMERICAN VETERANS
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
OF THE
HOUSE COMMITTEE ON VETERANS AFFAIRS
May 2, 1985

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the more than one million members of the Disabled American Veterans, I want to take this opportunity to thank you and the members of the Subcommittee for allowing us this opportunity to present our views on legislation relating to the Veterans Administration health care system.

H.R. 788

Mr. Chairman, the provisions of H.R. 788--introduced by yourself on January 30, 1985--would amend Section 4114(a)(3), Title 38, United States Code, relating to the Administrator's authority to hire certain employees within the Department of Medicine and Surgery (DM&S).

Under current law, the Administrator may employ, on a temporary, full time basis, individuals who have successfully completed a course of nursing from a recognized school of nursing pending their state registration as a graduate nurse. Such an appointment, however, is limited to no more than one year.

Mr. Chairman, this measure proposes to remove the statutory bar that limits to one year the duration of employment accorded to such graduate nurses pending their state registration.

In our view, enactment of this measure would serve to enhance the VA's recruitment and retention capabilities relating to the employment of nurses which, in turn, would favorably impact on the quality of health care provided to disabled veterans. We therefore support favorable consideration of the bill.

H.R. 789

Section 2 of this measure--introduced by yourself on January 30, 1985--proposes, through appropriate amendment to Section 620A, Title 38, United States Code, to make permanent and extend, through September 30, 1988, the Administrator's authority for furnishing care in the treatment and rehabilitation for alcohol or drug dependency or abuse disabilities.

Mr. Chairman, the DAV does not have a specific National Convention mandate regarding this issue, however, we do not object to enactment of this provision.

Section 3 of the bill proposes, through appropriate amendment to Section 5033(a), Title 38, United States Code, to extend, for four years, through Fiscal Year 1989, the authority of the Administrator to make grants to assist states in the furnishing of domiciliary, nursing home or hospital care to veterans in state homes.

As you are aware, this program provides grants to assist states to acquire or construct state home facilities for furnishing domiciliary or nursing home care to veterans and expand, remodel, or alter existing buildings for furnishing domiciliary, nursing home, or hospital care, to veterans in state homes.

Without question, the domiciliary, nursing home and hospital care provided to this nation's veterans by state veterans homes has been most invaluable, offsetting the severe losses suffered by the VA's health care system in terms of bed reductions and budgetary constraints.

Recognizing the significant and important role of state veterans homes--in terms of care provided to the rapidly aging veteran population and the cost effective use of federal taxpayer dollars that supplement this program--the DAV supports enactment of this provision.

Section 4 of H.R. 789 proposes, through appropriate amendment to Section 5035(d), Title 38, United States Code, to remove the existing statutory bar that limits a state from receiving, in any one fiscal year, no more than one third of the total appropriated funds to conduct the state home grant program.

Mr. Chairman, it has been estimated by the VA that at the end of Fiscal Year 1984 there would be 38 unfunded state home projects requiring a total of $84 million for which pre-applications from various states have been received by the VA.

Assuming an appropriation of $34.5 million for Fiscal Year 1985, the VA estimated there would be 28 projects remaining--totalling $49.5 million--for which pre-applications had been received and funds required. With funds for these projects appropriated, they could be obligated absent the "one third" restriction embodied in Section 5035(d)(2). In fact, the VA has offered the "one third" limitation as one reason for grant applications not being funded.

Mr. Chairman, if enactment of this provision would, as suggested, permit the VA to provide sufficient funding to any of the states for completion of state home projects, the DAV would not object to its enactment.

H.R. 1303

Introduced by yourself, Mr. Chairman, this measure would permit the Administrator to effectuate an administrative reorganization within DM&S without regard to the requirements of Section 210(b)(2), Title 38, United States Code.

Specifically, DM&S would be authorized to "...transfer the functions of the Technology and Performance Evaluation Section and the Information and Education Service at the Veterans Administration Prosthetics Center in New York, New York, to a new Prosthetic Assessment and Information Center in the vicinity of Washington, D.C."

Mr. Chairman, the mission of the new Prosthetic Assessment and Information Center (PAIC) is stated as being the:

> "Principal organizational element responsible for managing/coordinating all administration, testing, evaluation, and information dissemination associated with prosthetics."

As we understand it, the PAIC will test and evaluate new commercially available devices/procedures; prepare and disseminate informational material and program guides regarding testing and evaluation; maintain data bases (catalogues, slides and tape collections, computerized systems, etc.) related to orthotics, prosthetics and sensory aids; and provide technical information and assistance.

While both organizational elements will be involved in evaluation, the Technical Development and Evaluation Unit will coordinate technical and clinical evaluations of newly developed, pre-production research protocols and techniques, and facilitate the movement of these devices and methods into commercial pre-production, distribution and use.

Alternatively, the PAIC will be performing evaluations and testing of new commercially available devices/procedures.

Additionally, the PAIC will serve as a primary point of contact for facilitating development of innovative ideas and suggestions outside the research structure from VA field personnel.

Mr. Chairman, in our view, it is imperative that the work of these two organizational elements be closely coordinated as co-location will serve to facilitate close coordination and interface.

From our discussions with VA Central Office program managers, we have been informed that 34 positions--24 of which are encumbered--now located at the VA Prosthetic Center, New York, New York, have been identified for transfer to Washington, D.C.

Additionally, 11 positions in the Office of Technology Transfer, Rehabilitation Research and Development Service will also be transferred from New York to Washington, D.C. and will be co-located with the PAIC.

As you are aware, Mr. Chairman, the DAV was actively involved and worked very closely with the VA toward the achievement of a reorganization and consolidation of all prosthetic activities within the agency.

During October, 1984, Administrator Walters approved a plan to implement the reorganization of Prosthetics and Sensory Aids Service and Rehabilitation Research and Development under the direction of a Deputy Assistant Chief Medical Director for Prosthetic Services, Research and Development.

The creation of PAIC constitutes a key element to the overall reorganization plan and serves as a vital component to its success.

We have been informed that the transfer of functions from New York to Washington, D.C. can be accomplished by October 1, 1985. However, in order to do so, a Congressional waiver of the requirements of Section 210(b)(2)(A) must be secured.

Mr. Chairman, in view of the DAV's strong and continued interest to witness the successful reorganization of all components of the VA's Prosthetic Program, we favor enactment of this provision.

Furthermore, it is our strong recommendation that the PAIC, in order to function at an optimal level, must be located in close proximity to the VA's Technical Development and Evaluation Unit, Rehabilitation Research and Development Service, which is currently located at the VA Medical Center, Washington, D.C.

Mr. Chairman, this concludes my statement. Again, the DAV appreciates having been given the opportunity to present our views of these important issues.

Statement of

The American Legion

1608 K STREET, N. W.
WASHINGTON, D. C. 20006

by

PAUL S. EGAN, DEPUTY DIRECTOR
NATIONAL LEGISLATIVE COMMISSION
THE AMERICAN LEGION

and

RODNEY S. BIRK, ASSISTANT DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION

before the

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS AFFAIRS
HOUSE OF REPRESENTATIVES

on

HEALTH LEGISLATION

May 2, 1985

STATEMENT OF RODNEY S. KIRK, ASSISTANT DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION
BEFORE THE SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS AFFAIRS
HOUSE OF REPRESENTATIVES

MAY 2, 1985

Mr. Chairman and Members of the Subcommittee:

The American Legion is appreciative of the opportunity to present to the Subcommittee, its views on the following bills the Subcommittee has for consideration: H.R. 788, H.R. 789, H.R. 1303, H.R. 1818.

H.R. 788 is a bill to amend title 38, United States Code, to enhance recruitment and retention of graduate and student nurse technicians by the Veterans' Administration.

This appears to be a categorical change in the intent of the second sentence of subparagraph (3) of section 4114(a), of title 38. We are advised by VA DM&S Nursing Service it is expected this change will enhance the ability of VA to recruit and retain needed nursing professionals in the Department.

Since The American Legion is supportive of all efforts to strengthen the professional services of the Department of Medicine and Surgery, we will express support for the bill.

H.R. 789 is a bill to amend title 38, United States Code, to extend certain expiring veterans health care programs, and for other purposes.

Section 620A of the title concerns VA programs for treatment and rehabilitation for alcohol or drug dependence or abuse disabilities. As originally enacted it was labelled a pilot program by Public Law 96-22. Enough experience has been accumulated by now that it should no longer be considered a pilot program. We do note the bill will place a time limit on the extension of VA authority to enter into contractual arrangements with halfway houses, therapeutic communities, psychiatric residential treatment centers, and other community-based treatment facilities for veterans suffering from alcohol or drug dependence or abuse. We presume the time limit is intended to afford the oversight Committees the opportunity to monitor the results of programs VA may develop that utilize the resources of community-based agencies. We commend this provision and we encourage the Subcommittee to pay close attention to VA efforts in this field of treatment for alcohol and drug abuse. We believe there should be a clearly visible intent of the Subcommittee to evaluate the effectiveness of the VA's efforts.

The American Legion has been strongly supportive of VA's efforts in the field of treatment for veterans with disabilities resulting from alcohol and drug abuse. Alcoholism particularly is a significant factor affecting the health of the veteran population, just as it is for the American people as a whole. VA deserves much credit for the fact that it began to help veterans with alcohol and drug problems before either private sector or community agencies were into this type of health care. VA has been involved in the development of various treatment modalities and technologies that are currently being used. We believe many of them are quite effective and are doing much good for veteran patients.

All that being so, at the same time we believe the activities of the VA in this field do need to be monitored consistently to insure the effectiveness of what is being done. The reason for this position on our part is that there is still quite a lot of experimentation being done in alcohol and drug treatment. And if some of the providers are not monitored they may get into all kinds of unproven treatment programs - especially if money is available - that may have no significant ability to actually help patients. Experience shows that as long as there is money to be spent people will find ways to spend it.

It is our belief that enough progress has now been made in this field that those treatment programs that are truly effective have been pretty well identified, as have those that are less so. We believe VA should now be focusing its efforts on those programs that have genuine possibilities of helping those veterans who have alcohol and drug problems. With all that is being done, it seems to us that we should begin to see, demographically, some measurable results in the effort to contain and alleviate the general problems of alcohol and drug abuse. Enough people have been and are being helped, by VA and through other programs, that the statistics should begin to show the results of all that is being done.

With those provisos, we certainly do support the intent of H.R. 789.

H.R. 1303 is a bill that has the simple purpose of enabling the VA Department of Medicine and Surgery to transfer from New York to the Washington, DC area the Technology and Performance Evaluation Section and the Information and Education Service ~~hitherto~~ located at the Prosthetic Center in New York. A new Prosthetics Assessment and Information Center will be established in the vicinity of Washington, DC.

We are aware that VA has been in the process of reorganizing the entire prosthetics service program to resolve problems that had developed over a period of years. Prosthetics is most certainly one of the most important aspects of the VA's health care program - given the clientele it has. We will be supportive of efforts to reach the goals that have been established for the service.

H.R. 1818 is a bill to authorize the Administrator of Veterans' Affairs to release a limitation on the use of certain real property conveyed by the Administrator to the city of McKinney, Texas.

We note the land in question was deeded to the city in 1965. We know of no reason to oppose the intent of the bill.

4/29/85

NATIONAL ASSOCIATION OF STATE VETERANS HOMES

Discussion Draft, April 16, 1985

"A Bill to Amend Title 38, United States Code, to provide for participation by more states in the program of grants to states for construction of State Veterans Homes."

Mr. Chairman, Distinguished Members of the Subcommittee, Hospital and Health Care, Committee on Veterans' Affairs, House of Representatives, the National Association of State Veterans Homes appreciates this privilege to express opposition for the need for "A Bill to Amend Title 38, United States Code, to provide for participation by more states in the program of grants to states for construction of State Veterans Homes rather than by the present method of funding said projects by the Veterans Administration."

The State Veterans Home Program has grown from eleven Homes in eleven states in 1888 to presently fifty-three Homes in thirty-four states. Nursing Home Care is provided in forty Homes, Domiciliary Care in thirty-nine Homes, and Hospital Care in six homes. These Homes presently have over 17,000 beds; and, in the Fiscal Year 1984, provided more than 4.5 million days of care. The State Veterans Home Program is an acknowledged, cost-effective alternative to providing long-term health services in Veterans Administration facilities.

The State Home Construction Grant Program began with the passage of PL 88-450, on August 19, 1964, which authorized Nursing Home Care. In addition to setting a per diem rate of $3.50 for State Nursing Home Care, the Act authorized a five-year program, supported by an appropriation of $5 million per year for Grants to states for construction of Nursing Home Care Facilities. The Veterans Administration could participate in such Grants up to 50 per cent of the cost of construction.

Subsequent Legislation which significantly changed the Construction Grant program is as follows:

a) 1969, PL 91-178: Expanded Grants for States for assistance in remodeling, modification, or alterations of existing Hospital or Domiciliary facilities in State Homes providing care and treatment for Veterans.

b) 1973, PL 93-82: Changed the participation rates from 50 per cent to 65 per cent and limited beds to two and one-half per 1,000 Veterans population of the state.

c) 1977, PL 95-62: Redefined construction to mean new Domiciliary and Nursing Home buildings and expansion, remodeling and alteration of existing buildings for the provision of Domiciliary Nursing Home Care or Hospital Care in State Homes and the provision of initial equipment to furnish such buildings.

This Act changed the Veteran occupancy requirement in State Veterans Homes receiving a Construction Grant from 90 per cent to 75 per cent.

This Act also changed the amount that any one state may receive in any Fiscal Year to one-third of the amount appropriated in such Fiscal Year.

d) 1979, PL 96-151: Removed the $15 million limitation for authorized amounts for Construction Grants.

e) 1980, PL 96-330: Removed the legal limitation of two and one-half beds per 1,000 Veteran population in a state and left to the Veterans Administration Administrator to prescribe the number of beds required to provide adequate Nursing Home Care to Veterans residing in each state. Regulations have established a ceiling of four beds per

1,000 Veterans with justification required if construction would result in nursing home beds in excess of two and one-half beds per 1,000 Veterans in each state.

f) Public Law 97-251: Extended authorization for the Construction Grant Program through 1986.

g) Public Law 95-258: Amended Section 5032 (Title 38, USC) to allow states to purchase facilities to be used as State Nursing and Domiciliaries.

Appropriated amounts since Fiscal Year 1975 for Construction Grant Programs are as follows:

FISCAL YEAR	AMOUNT (000,s)
1975	$ 9,700
1976	$10,000
1977	$10,000
1978	$15,000
1979	$10,000
1980	$ 7,500
1981	$15,000
1982	$15,840
1983	$18,000
1984	$18,000
1985	$34,500
1986	$22,000 ?

From Fiscal Year 1966 through January 31, 1985, $203,540,000 has been appropriated for Grants for Construction of State Extended Care Facilities. Of these monies, $149,993,000, through September 30, 1984, were obligated, involving 54 projects producing 7,203 beds and 115 projects for renovations, life safety, etc. Thirty-four states have received Grants covering 169 different projects, with the total estimated cost of $256,327,000 resulting in Federal participation of an overall 58.5 per cent of the estimated cost of the projects. Sixty-eight per cent of the projects were non bed-producing, related to renovation for programmatic changes and for Regulatory Agencies' requirements, life safety, privacy, etc. (Source--Office of Budget and Finance (Controller) Washington, D.C., 1/85).

States Without Veterans Homes are:

Alabama - awaiting funding
Alaska
Arizona - planning stage
Delaware
Florida - awaiting funding
Hawaii
Kentucky - inquired as to process
Mississippi - awaiting funding
Nevada
North Carolina
Oregon - considering
Tennessee
Texas
Utah
Virginia - expressed interest

Eligible preapplications and applications for Grants for Construction of State Extended Care Facilities approved/pending approval as of March 31, 1985, reflect an estimated Grant request of $181,167,000. The Fiscal Year 1985 funding of $34,500,000 with carryover funding will reduce the backlog of projects to $141,035,000. (For listing see Appendix 1).

The eligible construction/renovation projects as of March 31, 1935, funded for Fiscal Year 1985, and planned for obligation beyond, involve 30 bed-producing projects and 40 non bed-producing (renovation for programmatic changes, Regulatory Agencies' requirements, life safety, privacy, etc.).

To Amend Title 38, United States Code, to provide for participation by more states in the program of Grants to States for Construction of State Veterans Homes rather than by the order of application to the Veterans Administration would be a departure from the existing tested and effective system of fund allocation on a "first-come, first-serve" basis. The National Association of State Veterans Homes has looked at priorities over the years; however, the one process which exhibits no favoritism is on a "first-come, first-serve" basis. It has not been the "first-come, first-serve" method of awarding Grants that has been the problem. The problem has been inadequate funding of the Construction Grant Program.

The need for State Home Facilities is determined by the state and by the area-wide clearinghouses, Certificate of Need, etc., in the states applying for Grants. Most existing State Homes also coordinate such projects with Veterans Administration Medical Districts in the planning process. To further complicate the picture by having the Veterans Administration and the House and Senate Veterans' Affairs Committees decide priority of funding of projects based on needs as determined by the Veterans Administration will change the program from a state initiative to a federal initiative. For a state to be positively assured when funding will be available is critical. Such uncertainty of federal funding will be a deterrent in the planning process at the state level. With no assurance that they will receive funds and having to submit the formal application, including final specifications, drawings, bid tabulations and budget for a project prior to such decision, states will not want to become a part of the Program. It will be too expensive without a sure indication of sharing by the Federal Government. It seems to take several years for states to become interested in entering the Program or in upgrading present facilities to meet the ever-pressing Regulatory Agencies' requirements. With the suggested approach of requiring the Veterans Administration to prioritize based on such manipulable factors as the demand in the Veterans Administration for nursing home care and domiciliary care as appropriate, for Veterans eligible for such care in certain geographic areas, etc., would eliminate the current predictability of fund flow for states in the Program. It would pit state against state, Congressional

Delegation against Congressional Delegation and politicize a currently rational, predictable program operation.

Veterans Administration Regulations already outline additional criteria the Administrator utilizes in the awarding of Grants if a state desires to build more than two and one-half beds per thousand Veteran population within the state, not to exceed four beds per thousand Veteran population. (Title 38, USC, 5034 (1)), (See Appendix 2 for Regulations).

In summary, the membership of the National Association of State Veterans Homes recommends continuation of the "first-come, first-serve" method of awarding matching grants to states for the construction, remodeling or renovation of State Veterans Homes which has worked well both for the Veterans Administration and the states. Why change a good system that has been proven effective for 20 years?

To improve the effectiveness of this matching program, we believe the following recommendations are worthy of consideration:

(A) Fiscal Year 1986 funding be authorized at $34.5 million and this level be maintained as long as necessary to eliminate the current backlog of state home construction projects.

(B) Establish a provision for one-time funding or a separate fund for new states coming into the Program. Such applications could be forwarded by the Veterans Administration to the House and Senate Veterans' Affairs Committees for special consideration on a "first-come, first-serve" basis.

To fund construction of a State Home in a state without a facility would be less costly than Veterans Administration construction. The maximum cost to the Federal Government cannot exceed 65 per cent of the estimated construction costs. Construction and operation of State Home nursing care beds over the years has historically cost far less than Veterans Administration comparable programs.

Thank you, Mr. Chairman, for allowing us to present this Testimony.

Jack J Dack

Jack J. Dack, Legislative Chairman
National Association of State
Veterans Homes
Commandant, Iowa Veterans Home
Marshalltown, Iowa 50158

APPENDIX 1

ELIGIBLE PREAPPLICATIONS AND APPLICATIONS FOR GRANTS FOR CONSTRUCTION OF STATE EXTENDED CARE FACILITIES (PENDING APPROVAL)

(Dollars in thousands)

MARCH 31, 1985

FAI No.	State (Locality)	Project	Estimated Grant Request
24-004	MD (Charlotte Hall)	(4th Phase - 126 Dom/NH Beds)	5,298
08-007	CO (Rifle)	New State Home - 100 NHC Beds	2,426
42-006	PA (Hollidaysburg)	Boiler Plant Modifications	597
17-007	IL (Quincy)	Renovation Andrew	351
17-008	IL (Quincy)	Energy Conservation	117
17-009	IL (Quincy)	Fire Safety	325
26-002	MI (Grand Rapids)	Replacement Mann - 226 NH Beds	11,003
06-008	CA (Yountville)	Hospital Addition - 56 Beds	7,307
06-009	CA (Yountville)	Remodel Dom - C	2,384
06-010	CA (Yountville)	Remodel Dom - A	1,808
06-014	CA (Yountville)	Rem. Sec. D Dom-Life Safety	1,853
26-003	MI (Marquette)	New State Home 155 D/N	2,652
34-009	NJ (Paramus Phase I)	New State Home - 114 Bed NH	6,108
34-010	NJ (Paramus Phase II)	New State Home - 100 Bed NH	5,054
34-011	NJ (Paramus Phase III)	New State Home - 100 Bed NH	5,131
28-001	MS (Jackson)	New State Home - 150 Bed NH	4,388
30-002	MT (Columbia Falls)	50 - Bed NH Wing	1,203
25-029	MA (Chelsea)	Elevators	78
25-030	MA (Chelsea)	Renovations	76
06-012	CA (Yountville)	Remodel Hospital Ward 1A	118
37-N003	PA (Hollidaysburg)	Renovations-NHC-Grant Increase	99
37-N004	PA (Hollidaysburg)	Renovations-DOM-Grant Increase	191
13-004	GA (Milledgeville)	150 Bed NH	4,550
27-006	MN (Hastings)	Grant Increase	474
17-010	IL (Quincy)	Life Safety-Fire Alarm	144
42-008	PA (Hollidaysburg)	Renovation-Sommer-225 NH Beds	4,091
06-013	CA (Yountville)	Rem. Sec. B to NH-Life Safety	2,179
06-011	CA (Yountville)	Cooling Plant and Piping	1,359
06-015	CA (Yountville)	Rem. Sec. E Life Safety	1,729
06-016	CA (Yountville)	Rem. Hospital Support Service	1,300
06-017	CA (Yountville)	Rem. Nursing Home	1,557
06-018	CA (Yountville)	Rem. Sec. F - Handicapped	1,299
06-019	CA (Yountville)	Rem. Workshop-Sprinkler	98
36-002	NY (Long Island)	New 350 Bed NH	14,625
06-020	CA (Yountville)	Rem. Sec. H Dom-Fire & Safety	1,105
06-021	CA (Yountville)	Rem. Sec. J Dom-Fire & Safety	1,105
06-022	CA (Yountville)	Rem. Sec. K Dom-Fire & Safety	1,105
06-023	CA (Yountville)	Rem. Sec. L Dom-Fire & Safety	1,105
06-024	CA (Yountville)	Rem. Wings 1C-D, 2C-D, 3C-D NH-Fire & Safety	1,557
05-002	AR (Little Rock)	Conversion 70 Dom Beds to NH	195
42-009	PA (Hollidaysburg)	Renovate Dietary Building	1,800
44-003	RI (Bristol)	Domiciliary Renovation	1,138

APPENDIX 1

PAGE 2

FAI No.	State (Locality)	Project	Estimated Grant Request
12-001	FL	New State Home 150-Bed Dom	2,730
39-002	OH (Sandusky)	Grant Increase	221
29-004	MO (St. James)	Replace NHC Unit-100 beds	2,420
40-009	OK (Clinton)	Replace 50 Bed NHC Unit (+10 beds)	965
16-002	ID (Boise)	Renovate Dom Wing into Dom/NHC Beds	1,105
39-009	OH (Sandusky)	Power Plant	1,409
06-025	CA (Yountville)	Remodel Wards 2-3 E	813
06-026	CA (Yountville)	Remodel Annex I	1,170
06-027	CA (Yountville)	Remodel Annex II	1,170
06-034	CA (Yountville)	Remodel Ground & 1st Floor	650
06-028	CA (Yountville)	Remodel Dom Sec. G & LSC	1,463
54-003	WV (Pruntytown Phs. I)	Remodel School for 202 NHC	2,961
54-004	WV (Pruntytown Phs. II)	Remodel School for 94 Bed Dom	2,602
06-031	CA (Yountville)	Renovate Kitchen & Dining Room	195
06-032	CA (Yountville)	Renovate Hospital Food Service	195
06-029	CA (Yountville)	Renovations-Storage Areas	195
06-033	CA (Yountville)	Renovations-Sprinkler System	98
06-035	CA (Yountville)	Renovations-Admin. Building	98
39-003	OH (Sandusky)	New 300 Bed Dom Replacement	9,223
39-010	OH (Sandusky)	New 200 Bed Dom Replacement	5,188
01-001	AL (Alexander City)	New 150 Bed NHC	4,615
29-005	MO (SE)	New 150 Bed NHC	5,850
29-006	MO (NW)	New 150 Bed NHC	5,850
39-011	OH (Sandusky)	Add 100 NHC Beds, Secrest	2,918
40-010	OK (Claremore)	New 250 Bed NHC	8,450
42-010	PA (Pennhurst Phase I)	Renov. for 180 NHC; 150 Dom	4,011
42-011	PA (Pennhurst Phase II)	Construct 270 NHC Beds	7,670
45-002	SC (Anderson)	New 220 Bed NHC	5,850
			$181,167

Summary (As of March 31, 1985)	
Funds Available from FY 85	34,500
Funds Available from FY 84	9,192
Funds Available from FY 83	5,202
	$ 48,894

Remarks:

1. 13-004 GA Estimate decreased to $4,550 from $5,902

APPENDIX 2

TITLE 38, USC 5034 (1)

6171 (§17.171). (MAXIMUM NUMBER OF) NURSING HOME BEDS REQUIRED FOR VETERANS BY STATE

(A) For purposes of these regulations, Appendix A prescribes the (maximum) number of beds (which may be necessary) to provide adequate nursing home care to veterans residing in each State. (When the beds to be constructed in a State will result in more than two and one-half beds per 1,000 veterans, the State shall provide sufficient justification for the Administrator to determine that the additional beds are required in that State. In making this determination, the Administrator shall consider the following factors:

(1) Demographic characteristics of the State's veteran population,

(2) Availability, suitability and cost of alternative nursing home beds to meet the needs of veterans in that State,

(3) Waiting lists for existing State nursing home facilities and

(4) Any other criteria which the Administrator shall deem appropriate to provide adequate nursing home care).

(PL 88-450, sec. 4(a) as amended by PL 89-331, sec. 7(b): PL 93-82, sec. 403(d); PL 94-581, sec. 206(b); (PL 96-330, sec. 404;) U.S.C. 5034(1)). (Dec. 23, 1982) (Veterans Administration Regulations Medical Transmittal Sheet 145, Veterans Administration, Washington, D.C., December 23, 1982)

APPENDIX 2 - PAGE 2

APPENDIX A-- (S 17.171) TITLE 38, U.S.C. 5034 (1)

Rank	State	Veteran Population	* Number of Beds
1	California	3,003,000	12,012
2	New York	1,951,000	7,804
3	Texas	1,732,000	6,928
4	Pennsylvania	1,593,000	6,372
5	Florida	1,392,000	5,568
6	Ohio	1,385,000	5,540
7	Illinois	1,348,000	5,392
8	Michigan	1,117,000	4,468
9	New Jersey	925,000	3,700
10	Massachusetts	720,000	2,880
11	Indiana	680,000	2,720
12	Virginia	664,000	2,656
13	North Carolina	660,000	2,640
14	Missouri	647,000	2,588
15	Georgia	632,000	2,528
16	Washington	628,000	2,512
17	Wisconsin	574,000	2,296
18	Maryland	544,000	2,176
19	Tennessee	543,000	2,172
20	Minnesota	525,000	2,100
21	Louisiana	453,000	1,812
22	Alabama	436,000	1,744
23	Connecticut	413,000	1,652
24	Kentucky	405,000	1,620
25	Colorado	401,000	1,604
26	Oregon	400,000	1,600
27	Oklahoma	397,000	1,588
28	Arizona	383,000	1,532
29	Iowa	354,000	1,416
30	South Carolina	351,000	1,404
31	Kansas	300,000	1,200
32	Arkansas	270,000	1,080
33	Mississippi	245,000	980
34	West Virginia	243,000	972
35	Nebraska	191,000	764
36	New Mexico	162,000	648
37	Utah	155,000	620
38	Maine	154,000	616
39	New Hampshire	138,000	552
40	Nevada	137,000	548
41	Rhode Island	126,000	504
42	Idaho	121,000	484
43	Montana	108,000	432
44	Hawaii	99,000	396
45	South Dakota	80,000	320
46	Delaware	77,000	308
47	North Dakota	69,000	276
48	Wyoming	67,000	268
49	District of Columbia	65,000	260
50	Vermont	64,000	256
51	Alaska	50,000	200

Estimate as of March 31, 1983. Source: Office of Reports and Statistics, Veterans Administration. (Based on last available census data - June, 1983)

*Number of beds per State subject to change due to shifting state Veteran population.

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSE

CHAIRMAN EDGAR TO VETERANS' ADMINISTRATION

Question 1. In preparation for this hearing, I wonder if you had a chance to review the evaluation report on the community-based treatment program for alcohol or drug dependent veterans which was submitted to the Committee last year?

a. Would you or a member of your staff care to summarize the report's conclusions?

Answer. The VA implemented a followup study on 1,160 veterans who were hospitalized for alcoholism or other substance abuse between 1981 and 1983. Data worksheets were collected on patients at the time of discharge from the VA medical center, and at the time of discharge from the contract residential programs; a subsequent 9 month followup evaluation was accomplished on all enrollments, both those discharged directly from VA medical centers into contract community programs, and those who were not discharged into such a transitional residential treatment environment, although they had been identified as likely to benefit from such placement. This second cohort of patients was discharged from VA medical centers into traditional outpatient clinic treatment activities. Thirty-three VA medical centers participated in the followup study.

The report's conclusions were that both treatment benefits and substantial measures of cost effectiveness were associated with the contract community-based halfway house rehabilitation experience.

The 9 month followup data revealed that 67 percent of those who completed a contract residential program (in lieu of traditional outplacement treatment) were abstinent from any use of alcoholic beverages; 63 percent of them were still actively participating in Alcoholics Anonymous (AA) meetings; 33 percent fewer detoxifications were required during the 9 months period for the contract program completers; full time employment had increased by 61 percent, in contrast to a 35 percent increase in the comparison group; average monthly income from full time employment had increased 71 percent, in contrast to a 26.6 percent average increase in monthly income for the comparison group; and 16.3 percent of the contract program completers had been readmitted to VA inpatient alcoholism programs during the 9 months period, for an average length of stay of 3.5 weeks, in contrast to a readmission rate of 17.3 percent for the comparison group, and an average length of stay of 5.2 weeks.

Question 2. I believe the firms which prepared the study acknowledged that there were serious problems looking at the long term effects of this program. Would you comment on how that affects the validity of the report?

Answer. The firms contracted to develop the data analyses and the report noted that the short term data collection was quite complete (i.e., a 92.4 percent capture of evaluation data on patients at the time of discharge from non-VA contracted programs). However, the 9 months followup data capture percentage was considerably less. This risk had been considered as a probability at the outset of the study, but there was a recognized need to sample for geographic (regional) differences in philosophy of care in the non-VA community programs, and to have representative sampling of the range of VA alcohol and drug dependence programs. Therefore, the large initial sample, ultimately 765 (placed) and 395 (not placed) patients, was selected. Despite the study limitations, which were important, sufficient data were available to describe the contract linkages established during implementation of the pilot program, to draw significant conclusions regarding how the pilot program was working, and for whom, and to make a valid cost benefits assessment.

Question 3. What other limitations or weaknesses of the report do you believe the Congress should be aware of?

Answer. The report covered a sample of the more typical range of VA locations and care models. It did not include data from atypical VA locations such as Anchorage or Honolulu, where VA does not operate an inpatient treatment facility but instead depends on military hospitals to provide acute care, and to select those veterans who would best benefit from non-VA contract community-based programs.

Another weakness of the report was the limited period of followup. Due to the requirement for a report submission by March 1984, and the need for a representative VA-wide sample of contract utilization experience, a 9 month followup was the longest followup period possible. A longer period, at least one year, would have been preferred, so as to measure the stability of treatment effects across a longer period; this would have facilitated comparisons of this modality with other one year followup studies in the medical literature.

Question 4. How much was the average cost for treatment in a community residential program?

Answer. The average per diem cost for treatment in a community residential program was $25.39 in FY 1983, the year the cost data were collected for the study, and in FY 1984, it was $26.82. It is projected that the per diem cost will be $31.17 for FY 1985.

Question 4(a). How does this compare with VA treatment costs?

Answer. The average per diem cost for treatment in a VA residential treatment program which provides a therapeutic community type of treatment, was $41.98 in FY 1984. This would compare with the non-VA contract program's average per diem of $26.82 during the same in FY 1984.

Question 4(b). Do you think that looking strictly at VA costs, this report supports a conclusion that this program is cost effective?

Answer. Most assuredly, yes.

Question 5. In view of the difficulties in following up on patients who participated in the study, do you believe that another study would be worthwhile?

Answer. Yes. However, additional study should focus on considerably more detailed data collected on a small selection of veterans, with extraordinary efforts to make successful followup contacts, with outcome evaluations on close to 100 percent of the sample. We have representative samplings of data on regional/geographic differences in halfway house program activities, and their sources of other community support. We have representative samplings of a broad spectrum of veterans' special needs, for vocational upskilling, for health education, for human relations skills, and for direct medical care. We need to conduct more detailed assessments on a smaller number of newly admitted veterans, to identify the particular clusters of background experiences which shape the natural history of their alcoholism, and in more detailed data collections during the followup phase to identify which particular intervening experiences appear to trigger relapses in those patients who are readmitted. Our ultimate goal is to provide definitive treatment, just what the veteran needs, and to more toward more individualized treatment plans.

Question 5(a). Do you have any plans to conduct or monitor future research in this area?

Answer. We are developing plans for more detailed assessments and followups on a smaller cohort of veterans, as just described. It is likely that budget for a contract will be required to augment the work of the VA staff persons involved. In the interim, we will monitor studies in this area, as reported by the National Institute on Alcohol Abuse and Alcoholism, the National Institute on Drug Abuse, the Association of Halfway House Programs of North America, and others.

Question 6. Can you point out the similarities between patients in VA alcohol or drug dependence treatment programs, residents of VA domiciliaries and those involved in community treatment programs. What percentage of persons residing in VA domiciliaries have past or present substance abuse problems?

Answer. From the standpoint of alcohol or other drug dependence, the symptoms of the addictions are quite similar at these 3 different levels of care: alcohol-related liver disease, organic brain syndrome, hypertension, and other alcohol-related diseases are often seen in each of these residential care programs. However, veterans directly admitted to VA medical centers often have critical medical or psychiatric problems which require specialized skills and immediate interventions.

The most recent VA-wide census study, which included 100 percent of domiciliary residents, indicated that 35 percent of all residents there have an alcohol or drug related problem which would benefit from treatment.

Question 7. Are there techniques or methods employed in community based programs that are adaptable to a setting such as a VA domiciliary?

Answer. Yes. In fact, the development of alcohol-free zones for living has already been activated at a number of VA domiciliaries, with regular Alcoholics Anonymous meetings supported at the domiciliary, and, for service connected veterans, vocational assistance services are available.

Question 8. Are there disincentives at work in VA benefit programs which encourage persons with substance abuse problems to remain in VA treatment programs or in VA domiciliaries, and discourage them from choosing community treatment programs?

Answer. In almost all cases, the answer would be "no!" However, an employed veteran may elect to be discharged to further outpatient treatment rather than community residential programs, as a help in shortening his residential stay, and getting back to work before he loses the job.

In general, there are almost no disincentives at work in this area.

Question 9. Does the VA have any contracts with treatment programs that offer both residential and outpatient treatment programs. What I am thinking of are programs like the Betty Ford Center in California, which is a visible and apparently successful program.

Answer. We do not presently have such contracts.

Question 9 (a). Do you think that the VA has clear authority to contract with such programs if such a contract is either necessary or desirable?

Answer. Yes.

Question 9 (b). Can you provide for the record information on the comparative rates of success of such non-hospital programs, and any information on cost efficiency?

Answer. We do not have data on the comparative rates of treatment success or outcome at the Betty Ford Center or similar programs.

Question 10. The discussion draft of the amendments to the State Nursing Home Grant Program would have required prior Congressional authorization of each grant. The bill I introduced yesterday does not include this provision. Instead, it authorizes grants in the amount of $40 million in FY 1986, $45 million in FY 1987, and $50 million in FY 1988.

How does this affect your reservation about this proposal?

Answer. We are pleased that the requirement for Congressional authorization of each grant has been removed. This eliminates some of the uncertainty about whether an application would be funded.

The elimination of the requirement for Congressional authorization for each grant and the inclusion of specific amounts to be authorized do not alter our reservations about changing the current grant award process to one based on relative need as determined by the VA. We still believe that this proposal could be counter-productive in that it could discourage many States from applying for their initial or additional State home construction grants.

Question 11. What has been the experience of the VA with regard to the delivery for contract health care services in the Virgin Islands?

How has the hospital patient load and incidence of the provision of medical services in the Virgin Islands compared to Puerto Rico and the contiguous 48 states?

Answer. Although specific workload figures are not reliably available between Puerto Rico and the Virgin Islands an estimate of the respective contract and fee-basis funds spent respectively follows:

	1984 estimates
Virgin Islands:	
Contract hospital	$1,202,000
Fee-basis outpatient	720,000
Total	1,922,000
Puerto Rico:	
Contract hospital	13,134,000
Fee-basis outpatient	4,755,000
Total	17,889,000

Workload data for Puerto Rico and the Virgin Islands is merged. Additionally, workload data does not delineate between service connected and non-service connected patients treated on a fee or contract basis. Therefore, the most appropriate comparison between Puerto Rico and the contiguous United States is overall patient load, i.e. both treatments provided by the VA and treatments paid for, but not provided by the VA. These data are presented as a ratio:

Inpatients treated Per Veterans Capita:

48 Contiguous States: 1,293,368 divided by 27,755,000 equals 0.95.[1]

Puerto Rico: 20,733 divided by 127,000 equals 0.16.[2]

Outpatients treated Per Veterans Capita:

48 Contiguous States: 18,157,224 divided by 27,755,000 equals 0.65.[3]

Puerto Rico: 340,225 divided by 127,000 equals 2.7.[4]

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[1] That is, for every twenty veterans living in the U.S., the VA treats one inpatient.

[2] That is, for every six veterans living in Puerto Rico, the VA treats one inpatient.

[3] That is for every three veterans living in the U.S., the VA provides two outpatient visits.

[4] That is, for every veteran living in Puerto Rico, the VA provides somewhat more than two and one-half outpatient visits.

Overall, based on this methodology, the incidence of treatment of veterans in Puerto Rico approaches three times the incidence inthe contiguous United States.

Question 12. Please provide information for the past three fiscal years concerning the utilization rates and dollars expended on services in Puerto Rico and the Virgin Islands under the extraordinary authority of section 601, title 38, United States Code.

Answer. The following data reflect utilization rates for fiscal years 1982, 1983 and 1984 in Puerto Rico and the Virgin Islands. These rates are shown as a ratio of the total veteran population in Puerto Rico and the Virgin Islands to the number of veteran patients treated in VA and non-VA facilities. Also included is the total VA medical care dollars spent for this period for veterans in Puerto Rico and the Virgin Islands. It should be noted that, in fiscal year 1984, while the average cost per veteran patient in Puerto Rico was $1,145, the average cost in the 48 contiguous states was $2,378.

	Veteran population		Total medical care
	Patients treated	Outpatient visits	
Fiscal year 1984:			
Puerto Rico and Virgin Islands	6.1	0.37	$94,607,000
Fiscal year 1983:			
Puerto Rico and Virgin Islands	6.2	.37	81,753,000
Fiscal year 1982:			
Puerto Rico and Virgin Islands	6.4	.39	89,454,000

HON. JOHN PAUL HAMMERSCHMIDT TO VETERANS' ADMINISTRATION

Question 1. When is it expected that Florida will be getting its state home?

Answer. Based upon the eligible preapplications on hand, Florida's position on the eligible list, and an estimated appropriation of $22 million for Fiscal Year 1986 and future years, it is estimated that Federal funds will be available for VA participation in the Florida construction grant in Fiscal Year 1988.

Question 2. Have any particular states voiced a concern about the draft bill to change the State Home Grant Program?

Answer. A staff member of Congressman Mrazek (D-NY) has expressed concern that an application for a state home in Long Island would be affected if the method of funding was changed.

Question 3. What is the basis for the estimated increased administrative cost of the State Home Program? What is the current administrative cost?

Answer. The current administrative annual cost is approximately $273,000. Direct administration is provided by a program coordinator, an assistant, and a secretary for an annual cost of approximately $120,000. Support is provided for the technical review of applications by the Office of Construction, Engineering Service, and other VA staff for an estimated annual cost of $153,000.

It is estimated that five additional FTEE (three program administrators, and two clerical staff) would be needed to implement the requirements of the bill. These personnel would primarily be involved in determining the relative need for projects. Their responsibilities and duties would include:

1. developing methodologies for determining veterans' needs for nursing home and domiciliary care in each State, compatible with the MEDIPP methodologies to determine needs in each Medical District.
2. annually calculating for each State the needs and the extent to which the needs are being met or are planned to be met by VA, VA supported community and State home facilities so as to determine the relative need for additional bed capacity.
3. annually obtaining from States their current methodologies for health care planning, particularly for nursing home care and alternatives for nursing home care. Analyzing these methodologies and plans to develop, if possible, a common basis for comparison of need as determined by the State.
4. comparing needs as determined by the VA and by the States to determine the relative need for State home facilities.

Further, it is envisioned that a Merit Review procedure would have to be established involving experts in health care planning to evaluate need and supported by experts in all of the technical fields of a construction project, and possibly representatives of providers and consumers of health care. The establishment of such a Merit Review Board of experts would be very costly and time consuming, entailing extensive investigation and travel to evaluate projects. Our estimate for these additional costs is conservative at $240,000 annually.

Question 4. What is the VA's long-term outlook for the contract hospital care situation in Puerto Rico?

Answer. The VA plans to eventually eliminate all contract hospital care in Puerto Rico except for that emergency type care that will always be necessary; however, the precise timing is a function of Departmental priorities and appropriations.

The Veterans Administration has been aggressively pursuing overall improvement of the contract care program and has adopted a twofold strategy to resolve longstanding concerns regarding contract psychiatric inpatient services. The short-term strategy is to implement mechanisms that will monitor more effectively the care provided. The long-term strategy, as noted in the VA's January 1983, report to Congress on health planning for these veterans, is elimination of contract inpatient care by absorbing that workload into an expanded San Juan VA Medical Center.

VAMC San Juan has implemented several mechanisms to improve the contract inpatient services, particularly psychiatric care. For example, the VAMC's Psychiatric Intervention Center (PIC) was established in May, 1983 with the following goals: to improve the quality of the screening process for veterans seeking psychiatric care; to provide better and more cost-effective followup care of veterans not requiring hospitalization; and to provide a more comprehensive multidisciplinary assessment of patients in order to improve quality of care. All patients seeking psychiatric care, who can be seen during the PIC's current Monday-Friday day shift schedule, are screened at PIC. A multidisciplinary team provides comprehensive assessment of the patient and offers a variety of interventions or treatment modalities, including referrals to other service providers (both VA and non-VA) or appointments for return visits at PIC.

In June 1984, a contract hospital liaison psychiatrist was hired to monitor the following aspects of care: quality of care, length of stay, frequency of leave passes, and extensions of the period of inpatient care. All patients hospitalized for over one year are assessed to determine the need for continued hospitalization and the appropriateness of referral to an alternate therapeutic modality. The VA Medical Center has instituted a policy that triggers consideration of alternative forms of care when a contract hospital patient's leave of absence exceeds a certain length of time. The contract hospital liaison psychiatrist has undertaken a review of admission procedures at the contract hospitals to determine whether they conform to VA standards, and visits the contract hospitals daily in the performance of monitoring responsibilities.

The VAMC has established a contract psychiatric hospital review committee to inspect contract facilities and to provide clinical and administrative consults. In addition, the medical center has implemented a policy to review prolonged lengths of stay, and the Psychiatry Service is conducting a retrospective study of frequent users of VA inpatient psychiatric services to explore the possibility of alternative forms of care that would decrease "revolving door" admissions. These last two efforts will affect the availability of VAMC psychiatric beds and, therefore, the need for contract psychiatric care.

One index of the effect of these mechanisms on contract care is ADC in contract psychiatric hospitals, which declined from 502 in October, 1982 to 387 in August, 1984. Further, between October 1, 1982 and May 31, 1983, contract psychiatric hospital days of care averaged 12,792 patient days per month. Between June 1, 1983 and April 30, 1984, the average was 12,533 patient days per month, a reduction of 259 patient days of care per month.

The long-term strategy is to expand the VAMC at San Juan to accommodate the need for hospital beds currently under contract. The Veterans Administration anticipated OMB approval of advanced planning for this project in the immediate future.

Question 5. What statistical data shows that the pilot program for treatment and rehabilitation for alcohol and drug dependence and abuse disabilities has worked well in terms of treatment benefits and cost effectiveness?

Answer. The followup study on the pilot program revealed that: at the time of 9 months followup from VA hospital discharge, the veterans who completed the halfway house rehabilitation program had required 33 percent fewer repeat detoxifications in that 9 month period than the comparison group who were not outplaced into the halfway house programs: At the time of followup, there was a 61 percent increase in full time employment of those who had completed the halfway house program, compared with the percentage of employment at time of their VA hospitalization; in contrast, there was a 35 percent increase in employment in the comparison group which was not outplaced into the halfway house program. There was a 71.2 percent increase in average monthly income in the non-VA contract program completers, compared to a 26.6 percent increase in average monthly income for the group not out-placed into contract programs. The reasonably modest initial cost of contracted community-based care was quickly followed by improved health, adjustment, employment, and decreasing medical costs, and with sustained sobriety and active involvement in Alcoholics Anonymous (AA) groups and other rehabilitation.

Question 6. Are you saying that the control over abuse in the state grant process is appropriately in the appropriation of funds by Congress, and not in the approval of state home grants by the VA?

Answer. We do not believe that there has been abuse in the state home grant process. From the beginning of the program in 1965, applications have been processed and funded in the order received. No State has received preferential consideration for any reason. No application has been found to be unacceptable and, hence, disapproved.

States are unencumbered in submitting applications. There is no limitation on the number or dollar amounts of applications any State could summit in any year. States have submitted applications to meet their needs consistent with State resource availability. The only limitations applicable to all States are those provided by law such as: (a) a grant cannot exceed 65 percentum of the estimated cost of the project [38 U.S.C. 5035(a)(1) and (b)(2)]; (b) no one State may receive in any fiscal year more than one-third of the amount appropriated for the program [38 U.S.C. 5035(d)(2)]; and (c) a project will not result in more than the number of beds prescribed by the Administrator to provide adequate nursing home care to veterans in each State [38 U.S.C. 5034(1) and 5035(b)(4)].

The one-third limitation was enacted to prevent perceived potential abuses in the grant program through "front-loading" of applications from one particular State. In the Senate Veterans' Affairs Committee Report accompanying H.R. 3695 (P.L. 95-62) the Committee expressed the belief "that, in order to foreclose the possibility of inequitably large grants to a few States, some limit should be placed on the amount any one State may receive under the consolidated programs."

Section 4 of H.R. 789 would eliminate this limitation. We favor enactment of this section of the bill. The only effect of this limitation, under current operating and administrative procedures, is to delay approval of large State home grant applications until enough money to fund the grant can be accumulated from different fiscal years' appropriations.

NATIONAL ASSOCIATION OF STATE VETERANS HOMES

OFFICE OF: Chairperson, Legislative Committee

May 3, 1985

MAY 6 1985

Honorable G.V. (Sonny) Montgomery, Chairman
Committee on Veterans' Affairs
House of Representatives
Room 335
Cannon House Office Building
Washington, D.C. 20515

Dear Mr. Chairman:

The National Association of State Veterans Homes appreciated the opportunity to have its Legislative Committee present testimony to the Sub-Committee on Hospitals and Health Care on May 2, 1985, on the matter of HR-505, the Veterans Health Care Omnibus Bill. Our testimony dealt specifically with that part of the Bill relating to revision of the State Home Construction Grant Program.

Our Legislative Committee was privy, on very short notice, only to the discussion draft of the proposed amendments to the State Home construction funding mechanism. The discussion draft contained several provisions which we felt were detrimental to the total effort of Congress and the states to achieve greater state participation in veteran health care and our comments reflected this concern.

The National Association of State Veterans Homes Legislative Committee attended the markup session for the bills and thus became aware of the Committee's more recent version of State Home Construction Grant Amendments which the Sub-Committee adopted for reporting to the Full Committee on Veterans' Affairs. We have carefully reviewed the adopted amendments and are pleased to inform you that they are fully supported by the National Association of State Veterans Homes.

One major concern expressed by the Sub-Committee was that the current "first-come, first-served" grant award system operates to discourage those states newly interested in the Program from making application for federal funds. This discouragement was seen as a byproduct of the long waiting list for those funds which now exists due to the fact that states already providing State Home services have initiated action to get into the queue for funding. States not currently operating homes have not had the benefit of knowledge of the Program or how to use it.

Congressman Edgar questioned us as to whether we could support a division of the Construction Grant Appropriation into separate pockets for (1) funding of new Homes in new states, and (2) funding the correction, renovation and expansion of Homes already existing. We concurred in this approach but note that the concept did not appear in the language adopted by the Sub-Committee and forwarded to the Full Committee.

In an effort to assist with a resolution to the priority problem, we would respectfully offer an implementory suggestion. Perhaps it would be appropriate for the Committee Report directing Veterans Administration implementation of HR-505 to require that the Administrator's report submitted under Title 38, 5033a, 2A and B (i)(ii), contain two lists of recommendations; one being for new Homes in states not currently providing State Home services, the second being for states desiring to improve or expand their facilities. In this manner, we believe, a more equitable method for attracting new states into this cost-effective Program could be developed without penalizing existing State Homes. This could prove beneficial to both State and Federal Agencies, particularly if the appropriated program funding matches the authorized amounts contained in HR-505.

Mr. Chairman, let me again assure you that the National Association of State Veterans Homes fully supports your Committee's effort to enhance expansion of the State-Federal partnership which is so well developed in the operation of State Veterans Homes. We are pleased to support HR-505 and hope that our suggestion is worthy of further consideration.

Sincerely,

Jack J Dack

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JJD:rah

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